Breast Implant Illness: Why Your Symptoms Aren’t Showing Up on Labs Transcript

(Transcripts are generated by AI and may contain errors)

Introduction to Breast Implant Illness

What's happening at the tissue level on an implant now, according to this study, is more like organ rejection of a cadaver because your body's building up antibody and it's also activating its B-cell response.

And that's what happens in organ rejections. If you're overwhelmed with chronic health symptoms and still don't have answers, you are not alone. I'm Dr.

Javan and on redefining wellness with Dr Javin, we'll be exploring root causes like Lyme disease, mold and parasites. And I'll guide you with simple and practical steps towards real healing.

Hello, and welcome back to the redefine wellness podcast. I am your host, Dr Javen Moore. Today, I have Dr Rob Whitfield, who is one of the premier ex-plant surgeons, which we're going to get into what that is.

If you have any chronic conditions, anything that won't go away. Anything where you just simply feel stuck. and you've had honestly any kind of plastic surgery, you need to be listening today or if you know someone with breast implants, today is where we're gonna get into the information.

He's gonna give us a lot of snippets because we've talked, I've listened to him present at conferences and he has the details, the data and the research backing to make this useful and interesting so that you can actually get something out of it, not just go do surgery.

So thank you for joining me today, Doc. Thanks for having me on. I appreciate it. Yeah. So we're talking breast implant illness, which is something that honestly, a lot of people don't even believe in because how could it possibly be happening?

I want to start off with that. What is breast and plant illness and why is it real? Yeah, in 2019, I testified at the FDA hearings. If people were concerned about it not being real, the F. D. A.

called a meeting about and asked for testimony about that specific topic. So the way I look at it, where I define it is it's a chronic inflammatory process.

that a medical device in this place, a breast implant, is playing a role. It is not the only thing. As many of us who take care of patients with chronic illnesses find out, there's multiple things in their genetic history.

There's a multiple of things and their toxicity burden that they deal with throughout their life. They accumulate over time. You have gut health problems, they have sensitivities or triggers from their diet, and they hormonal disturbances for a number of reasons.

All those collectively go into making and informing what I see in front of me, which is usually a woman between 25 and 55 with tons of chronic inflammatory symptoms, including brain fog, fatigue, shortness of breath, chest pain, muscle and joint pain.

Maybe chronic UTIs, gut problems, psoriasis, total body acne. If you can come up with something, Jabin. I've been told it as a symptom. You know, I don't even remotely think I have all of it sorted out, but I can tell you when you listen to these poor patients tell, you know what they're dealing with, and then they get told they have normal blood work and they are fine.

That is one of the more frustrating things. And for the audience, this would all be sorted it out very simply if every

woman who had this problem showed up to the ER with a red swollen breast.

Right? Because it'd just be, that's infected. But we know when I explant them, a third of them basically have bacterial contamination, which leads to a big interaction between the breast tissue.

It causes more oxidative stress in those tissues. That leads more problems in the immune system, more activation, macrophages undergo polarization, and that leads into more symptoms.

So the long story, short story is there is a cause effect relationship with it and we're learning more and more all the time. So I want to tell a story really quick for everybody that maybe this will make it hit home a little bit more.

I had a woman that came into my clinic and she was very, very health oriented. She ate right, exercised, she slept right. she controlled her stress, She did all the things right She had been on the journey of healing for 10 years.

Most recent diagnosis was headed down MS, but she had it under control. She was really, really good for probably the last five years of time before she met me.

Very stable and good. And I started working with her. We saw a lot of progress for a while. Then about a year into working We just hit a wall, just an absolute brick wall.

She could not move forward. And things actually started worsening little by little, by a little. I had no answer for it. Nothing had changed. Lab work didn't change.

Protocols were previously showing really effective. And I just talked to her, I was like, you have breast implants? I knew that she had breast and implants.

We had talked about that being a potential trigger, but I wasn't going to immediately jump out and say, Hey, have to remove those. Let's see if we have progress first.

That's, that's where I started because I could tell she's like I want them and I identify, feel better with them in.

Why Breast Implant Illness Is Real

And. I said, okay, we're not going start there. So after this unfortunate flare up and it just stuck and wouldn't get better. I said, Hey, that's probably something you need to get evaluated.

She got her breast implants out. And within a few months, the flare was over. The symptoms were progressing. I mean, at that point, fortunately we were, we're blessed because she was fully confident that it was the right thing to do and we are moving forward.

And it's not always that black and white with they're out, I'm better. A lot of times there's some work to. Between there, but that's just one of those stories.

I've got so many of them with women that I worked with that for me anymore, it is not a, is this potentially a problem? It's like, no, this is absolutely a problem for so many women, not a hundred percent of women with breast implants, but so of them.

And it's for the ones that seem to be okay now, it is still a burden on their body. It still not good. it just may not have broke you yet. with BII just simply had some sort of you know red light that just switched on like yeah it's a problem now or a massively inflamed breast where it looks infected people would take them seriously but instead it almost always every experience I've had I'm sure you've different ones that were maybe more visible I have never had a woman tell me I can tell that this is the problem on this breast I could just visually see bruising and this and that.

None of them ever said that they're just like, they said internally, I just feel something's wrong. Yeah. And I don't want to make light of it. It's very hard as a provider to understand the problem because it doesn't really fit your I

mean, make a diagnosis based on these symptoms of like, what are you supposed to do?

So I don't really listen to the patients to quote unquote make diagnosis. I didn't tell anybody to have an explant surgery. To your point, everybody's arrived at that conclusion by the time they get to Austin, Texas.

They've probably, you know, stalked me for many, many months to years, either on Instagram or YouTube or whatever and read the books we've written and the shows we'd done.

It's a big decision. They're all concerned. Is it going to help? And I think anytime you reduce your toxic burden, however, when a, you know, I, think you've highlighted like throughout life, if you have a lot of things that build up over time and that creates, a difficult, situation and you add into it a device that we know causes inflammation.

I mean, it's silly to think it doesn't. And the more evidence that mounts that certain individuals have far more problems with it than others, and that's typically what you're seeing and I'm seeing, the people who are healthy and just running around doing fine, you don't see them.

Can I jump in here and ask? You said there are certain people that have more problems. Can you give any context to that? Is there genetic types or body types, or personality types?

Yeah, for the genetics, we think very strongly, and we're getting this research evaluated now, that our patients, about 83% of them have mutations or single nucleotide polymorphisms in the antioxidant pathways, the glucuronidation pathway, methylation pathway and the vitamin D metabolism pathways.

If you just add into that a problem with hormone metabolism where they have high amounts of estrone, that's kind of the perfect storm, if you will, of a patient who's going to have this problem.

That's really, really interesting. Honestly, you may have just came up with your next business and said, my brain's just running here. I'm like, man, if you start a lab company that says before you go do this, Botox, filler, breast implants, You name it.

You should run this testing and make sure that you don't fall in this category because your likelihood of ending up a problem is X, Y, Z. I mean, that could be really helpful.

So, we do have that. Yeah. We do that it's called the Sharp Method and the wellness testing that you're talking about we have after… So I'm really specific about the stack, Dr.

Moore. From a supplement standpoint, I operate on patients with supplements. You've probably heard like surgeons typically discontinue all supplementation two weeks prior to surgery.

That's still at the platelets. and their function return to quote unquote normal. And that's usually because everybody's concerned about high, high antioxidant levels.

So I don't do that. I have a set of supplements that I'm very comfortable with in terms of balance that include antioxidants and we don't have problems with bleeding.

So we do the supplements starting from the time we first encounter and start working with them to help lower their inflammation to support the genetic pathways we just discussed.

So we use a lot of liposomals because I'm sure just like your clients, I have a lots of clients with a of absorption and gut problems. So, we used lipozomal formulations, a couple little powder formations with magnesium and amino acids and some proteins, things that are simpler for them to deal with.

And then we get the test done and we're looking specifically, hang a of what I do based on toxicity burden through Vibrant Wellness right now. They seemingly have, for me, the most information at one time that we can get, especially as it pertains to like mycotoxin burden.

And many of my patients have tons of micotoxins burden, I can tell you regionally, there's problems with obviously people in Florida. They get sprayed with all sorts of stuff, herbicides and pesticides, probably due to the Everglades and all the things in the area.

Who Is Most at Risk

Plus they have high amounts of problems, with molds from floods and hurricanes and Where you grew up, maybe you grow up around agriculture. So you're typically going to have a higher glyphosate burden.

If you group in a place with really bad groundwater, like I did, you are going have more arsenic in your system. I think, honestly for the audience, You don't know any of this until you start checking these things.

And I don´t listen to patients to make a diagnosis, I listen here kind of how they detox. Then I ask a lot of questions about where they grew where they traveled to, what kind of work they did.

Because those historical items, they'll tell you what's going on. If you just listen to them long enough, They'll invariably tell, you their parasite exposure history, their mold exposure, history lime, whatever the thing is that has not really fit into the box.

They will tell. And many times they tell Like, I went to India, or I want to South America, to the Caribbean, and I got sick for multiple days. And you ask them, well, did you get treated for traveler's diarrhea?

Did you you'll get any kind of treatment for that? The number one cause of liver abscesses in Africa is still intramuscular. So, you can very easily get a parasite and have a liver abcess in that part of the world.

It's well documented. Like malaria is a parasite, like all these things, if you just think about them and maybe just ask a few more questions, it won't be as hard for you to understand them as a provider.

You know, health history is one of the very first things you ever learn as is one of the first things I most forget as a doc, because we get into what we're doing.

We feel like the paperwork or whatever is enough. And I know as, a guy still in practice that sees complex chronic illness every single day, I re-ask what my paperwork says to the point where I've actually had a few people give me a little bit of a complaint.

Like, why are you re asking this question to my staff? And, 98% of the time, when I go back through your history, I get more than what you put into our documentation.

And I also just want to understand and hear your context because it helps me to understanding who you are. I mean, one of things that I run into all the times, genetically speaking, like what talked about with getting breast implants, if you're MTHFR, it's well known that you may not have the ability to absorb B12, a more common genetic marker.

Without B12, you have a higher likelihood of having anxiety and OCD, which makes you a little bit more of that perfectionistic A type, more anxious warrior type person, Which then dysregulates your nervous system, complex chronic illness pathway, which also, if you have breast implants, is going to make you a higher likely candidate of having BII.

So for me, just listening to someone explain their history and to what level of detail helps me understand who they are, Which then helps be put together where we need to go.

I can't agree more that just, listening is a key point. Yeah, absolutely. That's a must of time. And I feel rushed too, like by the time they get there, they're super like wound up, right?

So like coming to meet me or you, there like in-person now and they've been told all these things, most of which

have not helped them and made them feel worse either in general or specifically about this problem because it's not being taken serious basically.

Yeah. So I'm going to take us back a moment into some of the things that you said, because it's been really interesting listening to you and you are presenting on stage to teaching all of us doctors and.

You've talked about some studies you've done on bacteria associated to plastic surgery, breast implants, and you're finding that that's one of the causations that is triggering BII.

What have you found there? Yeah, in 2016, I had my first case of this particular problem where I just explanted somebody and what came back was an E. coli infection.

Pre-op, we had no idea they had any problems because all the labs, white blood cell count was normal, they have no changes on their examination. And this was a cancer patient who just wanted their breast reconstruction removed and an aesthetic flat closure.

So I did all that. And when we reviewed everything, now for me listening to get an E. coli infection from a hospital specimen, it has to be meet certain criteria, which is greater than 10 to the 6 per high power field under a microscope.

And then they get a sensitivity pattern. To boot means that person had basically got bacteremic, a blood-borne type situation. It attached to the device typically.

Now when we're older, things with our bowel and bladder are the most common reasons. Like an E. coli infection is typically going to be like bladder. So not always, but typically And so I try to explain to patients, the reason something like that happens is because our body has this elegant surveillance system.

But a device, hypni-breast dental cardiac implant, neurologic implant is not you. Once again, right, it's not you. Can't be recognized as self. So it can attach, the bacteria can attached to it and the device can't do anything about the bacterium.

Your body also cannot do any thing about bacteria.

Bacteria, Biofilm, and Immune Activation

Those things set up an environment for you to build, you know, colonies or biofilms of bacteria, and then that is what interacts with your tissues. Now, I think also, Dr.

Moore, it's important to understand that the scar tissue, which is big collagen sac that forms around any implant, hip, knee, breast, dental, whatever, is not impervious.

I thinks everybody's impression is this thing is impervius and it is It allows for interaction between the bacteria on the device and your tissue. It does not block the signaling.

So think of like a screen door. You can look through it. So it can interact. And I think that's probably one of the things that is not understood well enough.

What's that interaction cause? So we know 29% of specimens that I've ex-planted, we published a big series in 2024, 694 consecutive specimens. 29 percent have predominantly two bacterial species, staph epidermidis, which is on everybody's skin.

And then cutobacterium acnes, that's found on your face, neck, chest, shoulders. Just like it sounds, it's more found in acne. Those readily produce biofilm, so they aggregate in colonies and it makes it harder for your body to get rid of.

Now that interaction between the tissue and the bacteria is what leads to more and more symptoms. Now, a step further than that now is a paper was published in Denmark last summer that showed that patients who are having more scarring, like firmness, thickness, tightness like capture contractures, the term that you used, that term and system were created in the mid-70s by Dr.

Baker. And that's been used. It's a very subjective system. Recently, this paper showed at the level of the tissue, Instead of what I look at, which is DNA of bacteria, fungus, and mycobacterium that could be on the device, they're looking at levels of RNA to find what proteins are being made at the tissue level, because DNA could dead or alive, but RNA is obviously making protein.

So they found higher levels RNA. of different cell types. Now it's interesting because the plasma cells, the B cells and the T cells were all elevated.

Traditional thinking is it is just T-cells, like a foreign body reaction. I'll make this as simple as possible. The first kidney transplant was done between Siamese twins in the 60s by Dr.

Joseph Marie. required no immunosuppression because they have the same genetic code. They're identical twins. Everything after that requires immuno suppression or something to block the immune response.

So even a non-identical twin needs immunospression and then you get to cadaver. So all of that means is what's happening at the tissue level on an implant now, according to this study, is more like organ rejection of a cadaver organ.

Because your body's building up antibody and it's also activating its B-cell response. And that's what happens in organ reduction, which makes sense, right?

We have a whole group of patients who have more symptoms. So those symptoms coupled to bad genetic pathways or what's happening at the tissue level, the immune system activation is higher in those patients.

That's why I will always advocate for complete cap selectomy in every single case because I don't want to leave any of that behind. I think of it as any debris that comes off the shell of an implant can act as a stimulus to the immune system because your T cell receptors will find it foreign.

They'll respond. So if you were to just unzip the old incision underneath the breast, take the implant out, leave the capsule in, that debris, whether it's ruptured or not, is still there from the show interacting at the tissue level.

You'll have patients who have implant removal without capsulectomy still have the same symptoms they had before. And why are people leaving a capsule in there?

Why is there a controversy about that? We've talked in the past about it and you've mentioned different reasons why, but for the audience to understand as a surgeon, why they are leaving that in their?

So those, I think it's multifactorial. They're under the impression that what I just said to you doesn't happen. they think It's fine. I Think if you just use logic, that argument fails.

So I don't consider that really an argument, right? We already know that basically a third have bacterial contamination. so if we just take out an implant and leave the bacterial contaminations, what are you doing?

You're not helping. The other is say someone has a ruptured silicone device and under local, which has recently been sent to me, a patient who just had the rupture silicone removed and the capsule left in.

How easy do you think it is to remove rupertured silicon in an awake patient? I have no idea if it can be easy. No, no, and it's never going to be appropriate in my mind.

It's both inappropriate and not an ethical treatment of the patient. And the final and more irritating thing to me is a, I

feel like it, it I don't know the best way to describe it.

So if I. Don't do something anymore, say I, don' do no surgery anymore. I used to, but I know when someone calls the office and says they want a rhinoplasty.

I don't see them and say, oh yeah, I'll do your rhinoplasty. Right. I just say my office knows I didn't do them anymore. So if in fact you tell the patient that it's not safe to do a capsulectomy, that's a lie.

It's very safe. All right. They tell patients that you get lung injury, pneumothorax. In I think 2000 cases, we have less than nine or something. Once again, you're not injuring the lung.

Pneumothorax, as you enter the space where the long is, your not hitting the lungs. You create a positive pressure and a negative pressure environment and the one goes down.

All you do is remove the air and then close and it's fine. The patient's is fine, right? So that's fear mongering. It's not a safety issue. You can say you don't feel comfortable as a surgeon doing that because of a training issue or repetition issue.

That's fine. But you shouldn't scare a patient and say it's unsafe. Right? That is bordering on, once again, just being unethical. There's no safety issue with it.

I used to reconstruct people's chest wall over the lung for the cancer surgeons all the time. What are we talking about? We're talking the scar tissue and taking it off of the rib cage.

This is not hard surgery. Hard surgery is reconstructing the chest wall in a cancer case or reconstruct someone's jaw or making a microvascular breast reconstruction.

That's hard. Like taking scar tissues out of people and reattaching muscle and doing some fat simultaneously like I like to do to help the patients.

Why Complete Capsulectomy Matters

Yeah, there's steps involved and repetition is important, but it's not super technical surgery like I used to do for microsurgery for cancer reconstruction that would take all day.

And the patient had to have that surgery so they could eat or walk or so that they wouldn't be completely flat from a cancer operation. Those are difficult operations and they're hard on patients.

You have to be technically experienced and skilled to those. You talk about these things, not being that hard. And for the rest of us out here listening, we're going, man, wow, okay.

There's a lot going on, but that's why you're the expert. That's, why are you one of the premier guys doing breast implants? That is why, you have strong opinions because you've done thousands of them.

Yeah. I want to touch back into some of, the topic that you were saying, because I'm over here typing. Just because, I am interested. It makes great educational purposes for my clients.

And you said there's 29% of breast implants that you removed had two bacteria. You said that there is a breast implant activation of the immune system, just like organ rejection that are two of the things that you're really finding in there.

And it's being caused by basically the body identifying this breast implant as being foreign object, foreign to the buddy, not of itself. So it trying to defend itself in some way or fight the bacteria.

It's an immune modulated issue. As I was listening to you, I'm just thinking to myself, Not that I would ever

recommend this, but if we're having a reaction like an organ rejection situation, Have they tried doing?

I know what you're going to say. I don't know. Yes. So my tell is always just like, you are going say, have they put them on an immunosuppressive or a steroid?

So the best thing for me, Dr. Morris, when the patient comes into the clinic and I go through their history and they're telling me they've seen the rheumatologist, the dermatologist all the people, I wait till the end.

And I say, hey, did any of them give you a little blister pack of steroids ever? Did you try that? Yeah, yeah, and they tell a story and I take them back just like you took me back and say did you feel better when you started the steroids?

Do your symptoms go down, go away? What do you think they all say? Probably yes, because those things seem to make everything better. So that's your tell right there.

So basically, you know, then part of the argument is if it's having that level of activation, like we said, of organ rejection, how do organs not get rejected?

You have to be on. immunosuppressive medications predominantly in the old days, because I'm old now, steroid was a big part of that, prednisone, big of part that.

So every time someone tells me that in my head, I just think, well, they're going to be the group of patients who when I do this surgery right away, that are going start feeling better.

Because they've already shown you by treatment what's going happen. And it's like, I just, in my head I'm thinking like okay, this is going to be one of the cases that we do that right away the person is doing to start feeling better.

Cause you don't know, right? You have your client and you told them like I am concerned about this problem with implants. I don' know if this going solve everything, but we're kind of at an impasse here.

So I don't ever go online and say, Dr. Moore, hey, I want you all to give your patients a trial of steroids. And if they all get better, i want to think about speaking with them about surgery or refer them to someone like me who can then talk to them intelligently about it.

Now, there'll be a lot of people who don' t share that opinion. I dn't really care. Because if you just think abou what I just said and put together everything else we've been talking about, it makes sense.

You have immune system activation, so much so that the only thing that helps them is a tiny bit of steroid. You want to make the whole problem go away?

Why don't you do what they do in organ transplantation? A gram of steroids. a big immunosuppressant medication, then everybody can be happy, right? But then you're going to get other problems.

That's what I was saying earlier. I wouldn't really want to recommend somebody going on an immune suppressant drug because the side effects are nasty.

Part of the reason is I trained a very specific way and for four months of my first year of surgical training was on transplantation. That made, it was like doing an internal medicine residency in four months because all of those people had every single problem known to medicine and they were taking polypharmacy.

So I'm the surgery resident. And if one of the transplant patients came in with shortness of breath, you had to go the ER quickly. You had the, and it was a tiny little university ER.

And before you knew it, Dr. Moore, those patients would need to be intubated because they have no reserve. Shortness of breath in a transplant patient is MI or pneumonia and you're going to have to intobate them.

or get them upstairs really quickly to the unit because you have someone on all these immunosuppressive medicines. You can't trust the white count. All it's going to happen is the person's gonna crump right in front of you and need to be intubated rapidly.

And that would happen all the time. And just to give some translation for medical talk, MI is heart attack or myocardial infarction. So as you throw that out there, I'm like, the average person may not know that one.

Recovery, Support, and Fat Transfer

Yeah, heart attacks, strokes, pneumonias, like all this stuff, but on top of it, taking all these drugs to block the response that will tell you they're having that problem.

And that is always the hard part. People come in and they're like, no, DACA, I'm good on this category. I am good in that category, good with blood sugar.

Well, what are you on? Well I on a GLP-1 and I also on, this, that, and that. And I said, No, bloodsugar, you're not good. You're medicated. you are under control, but you aren't good Which makes everything different when people come in and their neutrophils, which is a white blood cell, sky high, I'm like, no steroids?

Taking antibiotics? No, No. Okay. Well then maybe we have a bacterial infection. You know, like going down the rabbit hole of like could it be this? Could it that?

and that's what you have to do with everything. And that why BII, breast implant illness, is such a important topic because it's not everyone's problem, but it sure the heck is a big ass problem for a large portion of people that have had breast implants.

I just love the details that you're giving here with reasonings why supplements that can be taken, not that your recommending it to each person because you got to evaluate them individually, there's a lot of Let's call it misinformation out there about what can and cannot be done with surgery, surgeons, breast implants.

And it's good to be clarifying with somebody that. Well, literally you have your hands in that topic every single day as what you do. There's no, well, I did that 30 years ago and now I'll talk about it or theoretically it could be it.

You're in it all day, which is why I wanted to talk with you. So then. What else comes to mind for you when you're talking about breast implant illness?

We've gone through kind of the type of people a little bit, the symptoms that cause it. We talked about the internal causations of it, and then you talked a bit about, you know, just some ins and outs of what you need to have done if you are deciding to do this procedure.

What do people need know? Well, I think, you know, this is a difficult situation, right? So maybe they've come to this conclusion with your help, your guidance, other providers have kind of nudged them along.

And maybe there at that point where they're like, okay, i'm willing to consider this and do this. But then it becomes like a whole logistical nightmare, for you to come Austin, Texas and spend a week, which is what I require.

It takes a lot of commitment, you know, from resources, time away from family work, et cetera. And I have a tremendous clinic and tremendous staff, as you, know here, we have human regenerator, a vertical hyperbaric chamber, filopressa for lymphatic massage from New Zealand, coupled with nano V therapy and a six foot tall red light.

We have all the things, right? So a lotta people are offering the surgery now, Dr. Moore. which is great because people have more access and that's all that should be happening.

They just need to do it the right way and ethically and help the patients get to in and out of the OR effectively, right?

Now, where I find it falling short is the programming around it.

Like you have programming to help with chronic illness. We have program programming help of chronic illnesses and the Sharp Method, the book I wrote about it was to make it less cryptic for surgeons.

So the only reason you don't know about is you're choosing not to try to know or not trying to understand about it, or still like we talked about earlier, denying that it exists.

So for patients, they just need support. And we created a group program that's remote that helps with this specific component, because I don't want women to have surgery and then not get supported the correct way that we've found that's, you know, from a psychosocial, emotional and physical standpoint, important to their recovery.

So we have a group of providers that actually have explanted with me who are functional medicine providers, and they are the people who run the program for me now.

I used to do it solo a long time ago, but obviously you and I both know that it's not something that is sustainable. They run the program, and they do group, they go through the testing, or they help patients really get to the other side, as you would imagine.

There's a lot of gut trouble in this group. I'm sure you've already seen that. It is by far the thing that takes the longest to sort out, whether it's underlying parasite, mold, whatever the sebo, whenever the things is.

And they work diligently with the patients over the years. So if you explain with someone else, you can still run our programming. That's good, that's really good to know because exactly what you're saying is just a surgery for my clients, not even just this surgery, but any surgery.

Anytime you go to the doctor and get an antibiotic, a Z-Pak. there's some things I want to do with you afterward because we want it to recover your body to its maximum ability.

You just went through some stress, some trauma, and some difficulties. So it's not ever just surgery. There's always so much more to it, right? It's just you got cut and sewn up and then you're all good.

And there is a process if you want that to actually work out correctly. I'm glad you are doing that because That makes it more easy for me because when I am telling people like, hey, yeah, you're doing this, that, and the other, but you've got to actually know how your body's responding to it.

So Doc, in the end, You're obviously the expert. You have proven that today. How do people get more information from you so that they can educate themselves or educate their family, their friends about this topic?

Yeah, I want to share one more thing and then I'll share how to get a hold of me. So I think the future of this Dr. Moore is explant surgery combined with fat transfer in a holistic transformation with their own genetically identical tissue.

That to me offsets what everybody's big concern is. What is the visual change going to be? I've looked this way for a long period of time. I'm very afraid to go back and look a certain way.

That's why I got this done. And so I do that transformation with fat. It's also something Dr. Moore oddly enough that a lot of people don't think is right to do as a plastic surgeon.

And the difference is the butt has the gluteus maximus and a big fatty layer and more real estate. The face, you want to put the fat close to the facial skeleton, the bones, not superficial because it'd be too visible.

And small amounts go a long way in the face. But in their chest area, we have this black box, right? So men and women both have breast tissue, so there's no confusion there.

Now, The fat goes with its fatty friends is what I like to say. You put The Fat where the Fat belongs and that's Okay, that makes sense, right? It's with its friends.

Genetically identical tissue in the right space at the time in their right amount will help all of this be easier for the patients. And you can learn more about this on our website.

We have put together a brand new website with the most information about breast implant illness, diagnosis, treatment, recovery, and breast implants associated cancers in Perfect.

Well, Doc, you are the expert. I appreciate your time. You probably need to get back to doing what you do all day, every day. So thank you so much. And until next time, hopefully I'll see you soon.

All right, thanks. Thank you for tuning in to Redefining Wellness with Dr. Javin. If this episode spoke to you, please follow and share this podcast with someone who is ready to take control of their chronic health symptoms.

Also, Please consider leaving a review. It helps more people find the show. See you here again.