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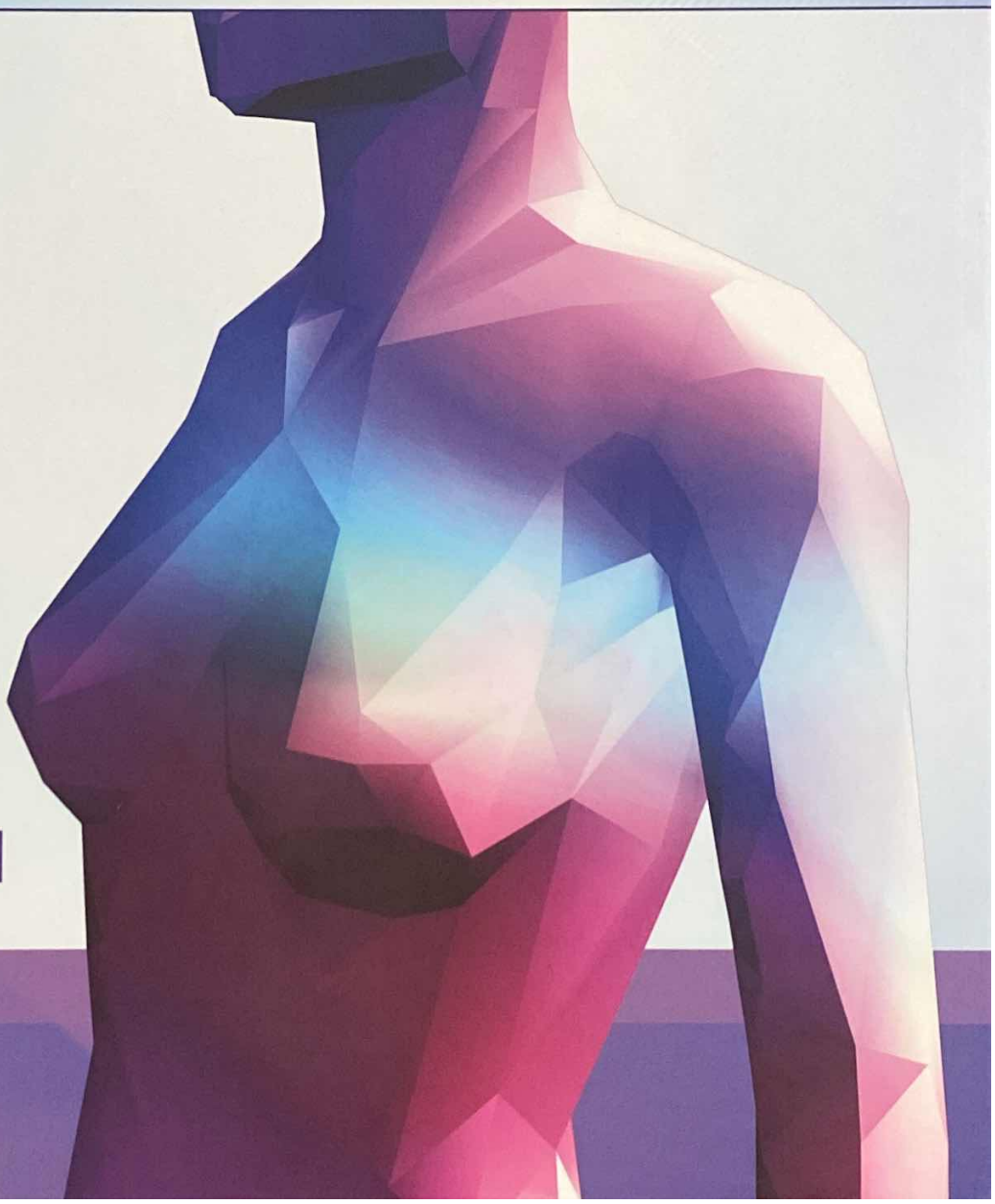
Atlas of Contemporary
AESTHETIC BREAST SURGERY



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Mastopexy—Periareolar Approach

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Introduction

Mastopexy is the surgical technique mostly employed for modification of volume, compaction, and repositioning of the breast mound. The harmonious combination of proportion, position, and projection requires a dermoglandular resection or, sometimes, exclusively skin resections, resulting in extensive scarring. The balance between breast shape and scarring has long posed a challenge to the plastic surgeon in search for lesser incisions that do not change the breast morphology. Periareolar mastopexy allows resection, compaction, and repositioning of the breast mound, providing wide surgical access, reduced scarring, and long-term stable results in specific cases.[1–8]

The senior author's experience in the field of breast-conserving surgery for breast cancer led him to explore the concept of using the periareolar approach in aesthetic breast surgery. In 1976, Dr. J.C. Góes described the resection of a breast quadrant by the periareolar approach and reconstruction of the resulting defect by approximating the glandular flaps.[9] This technique was the basis for the description of periareolar mammaplasty, first published in 1989.[10,11] The surgical technique was initially designed to reduce and reshape the breast for a more harmonious appearance. At that time, synthetic mesh interposition was not used for the stability of the aesthetic outcome. Instead, de-epithelialized periareolar skin excess was used as an internal "brassiere" to support the reshaped breast. However, this type of support was insufficient to provide a stable breast contour in the long term.

A mesh support was then innovated and was interposed between the reshaped breast mound and the skin flap to prevent tissue distention in the distal direction. Tissue stretch leads to widening of the breast base and areola, resulting in loss of aesthetic results in the short and medium term. The use of a mesh support provides long-lasting aesthetic results by helping maintain the proportion and position of the reshaped breast, allowing adequate tissue fixation, and counterbalancing healing forces and gravity.

Meshes of different materials have been used as a support system. First, a polyglactin 910 mesh was employed, because this is a fully absorbable mesh, but changes of aesthetic outcome were observed 2–3 years after surgery.[12,13] As a result, partially absorbable meshes started to be used as a support system, resulting in longer lasting aesthetic results.[14,15]

This chapter describes the refinements incorporated in the technique over the years, making periareolar mastopexy a treatment of choice for achieving satisfactory and long-lasting results in patients with mild to moderate breast ptosis and hypertrophy.

Indications and Contraindications

The parameters for indication of periareolar mastopexy include the degree of breast hypertrophy, degree of ptosis, quality of breast tissue (glandular and adipose tissue), and thickness and laxity of the skin. Thus the technique is particularly indicated in cases of mild to moderate breast ptosis, breast hypertrophy requiring up to 500 g resection per breast.

The surgical access via periareolar incision broadens the indications for breast-conserving surgery in the treatment of breast cancer, allowing breast reconstruction with preservation of the mammary gland structure, even after extensive resection. The technique is also a good alternative for correction of breast asymmetry resulting from oncologic surgery.

Patients with a history of any previous breast procedure, those showing signs of transient poor perfusion of the nipple–areola complex (NAC), and smokers should not undergo periareolar mastopexy, as described in this chapter.

Preoperative Evaluations and Special Considerations

A careful patient selection is fundamental for obtaining predictable and satisfactory results. The quality of breast tissue is an important selection criterion to be considered. Patients with a thicker dermal layer and greater skin elasticity experience a more efficient retraction and better tissue adaptation during wound healing, resulting in an aesthetically acceptable scar. In addition, long-lasting results are associated