

Breast Reduction: A Case Presentation

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Case

S.G is a 45 year old woman who was referred to the plastics clinic by her family doctor for mammary hyperplasia to discuss the possibility of reduction mammoplasty. She is currently a size 34DD. She explains that, although she has had large breasts since puberty, they grew significantly during her second pregnancy 10 years ago and did not return to their antepartum size after she stopped breast feeding. Since then she has experienced upper back, neck and shoulder pain which she attributes to the size of her breasts. Her bra straps make painful grooves in her shoulders and she occasionally develops a rash in the crease of her breast. She would like to start leading a more active lifestyle but finds exercising awkward and uncomfortable.

Physical Exam

S.G. is 5'4" and weighs 145 lbs, giving her a BMI of 25. On examination her breasts are hyperplastic and pendulous. The sternal notch to nipple distance is 27 cm, the notch to inframammary crease distance is 20 cm, and the crease to nipple distance is 7 cm. The plastic surgeon decides that S.G. is a good candidate for a vertical technique breast reduction and she is booked for surgery.

Preparation for Surgery

On the day of surgery landmarks are marked on S.G.'s breasts while she is sitting (see Fig 1 & 2). The midpoint of the chest is demarcated. A line is drawn

extending from the midpoint of the clavicle to the nipple. The anterior projection of the inframammary crease is marked on this line as point A (Fig 1). This point is where the upper border of the areola will sit after surgery. Curved lines that will form the new border of the areola are drawn extending to points C and D. Point B is drawn 2 to 4 cm above the inframammary crease and connected to points C and D via curved lines. After

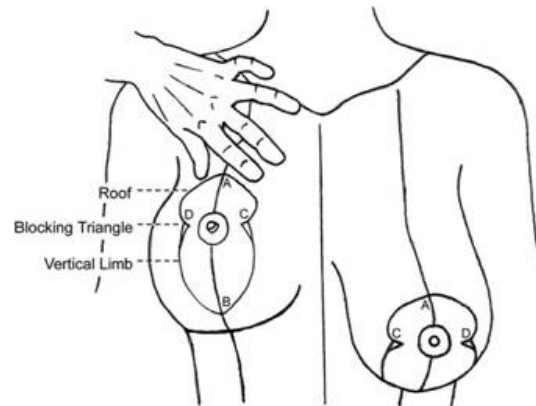


Figure 1: Surgery landmarks for breast reduction.

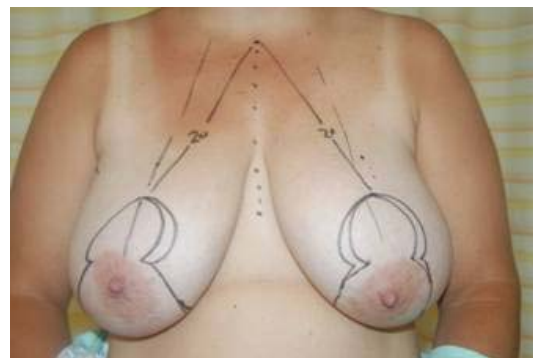


Figure 2: Surgery landmarks on patient.

a vertical breast reduction the inframammary crease moves up, therefore placing point D 2 to 4cm above the inframammary ensures that the scar will not extend onto the anterior chest wall. After drawing out the landmarks, the surgeon decides a medial dermogladular pedicle would be appropriate for S.G.

The Operation

In the operating room the breast are infiltrated with a Ringer's lactate/lidocaine solution. A tourniquet is then applied to each breast and the skin within the markings is deepithelialized (Fig 3A). The skin, fat and glands within the markings are excised laterally and superiorly, while ensuring a pedicle thickness of at least 2.5cm to maintain blood and nerve supply (Fig 3B). The excision is extended to remove tissue deep to the intact skin.

Skin flaps are kept at a thickness of at least 2.5cm. One or two 2-0 vicryl intraparenchymal pillar sutures are used to approximate the medial and lateral breast pillars. The vertical incision is then closed with 3-0 monocryl sutures in the deep dermis and a 3-0 monocryl subcuticular purse string suture to gather the skin (Fig 3C). Gathering of the skin decreases the size of the resultant scar. The incision around the areola is closed with a 3-0 monocryl deep dermal suture and a 4-0 monocryl subcuticular running suture. All incisions are then covered with Steri-Strips and the patient's chest is wrapped in plastic bandages. The operation takes about 2 hours.

Outcome

S.G. is taken to the recovery room where her recovery from the anesthetic is uncomplicated. She is able to leave the

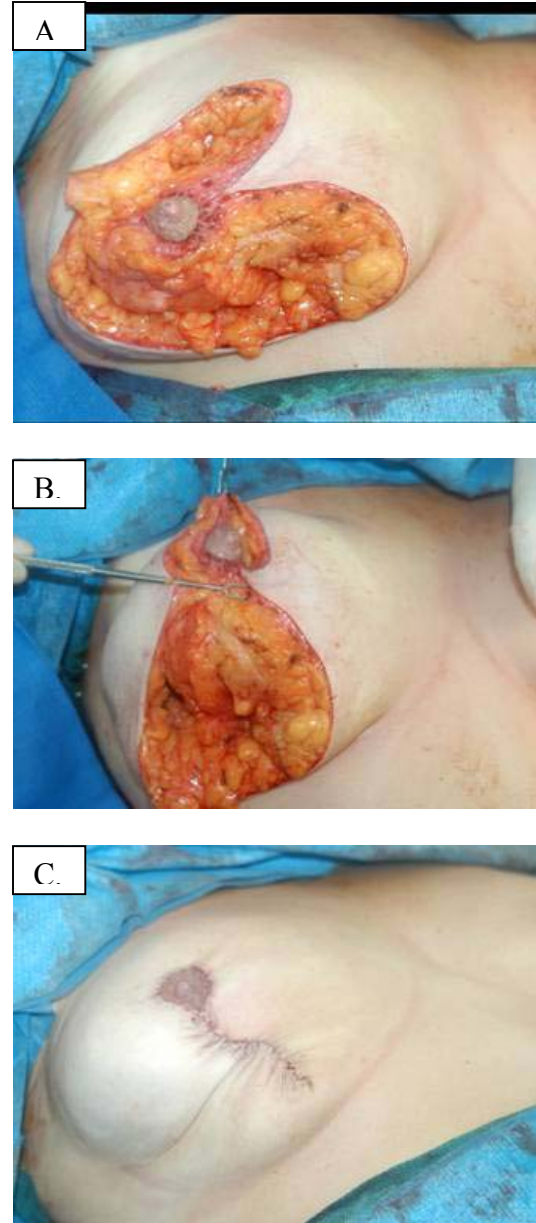


Figure 3: *A.* Deepithelialization. *B.* Removal of skin, fat and glands. *C.* Closure.

hospital within a few hours. She is seen 2 weeks postoperatively to have her sutures removed. The incision at this time appears to be healing normally. At her six month follow up visit S.G. tells her surgeon that her back neck and shoulder pain has decreased significantly since the operation, and that she no longer gets bra strap grooves in her shoulders or a rash under her breasts. On examination her incisions scars are



Figure 4: Post-operative photo of patient two weeks after surgery.

still red and slightly elevated. The breasts are slightly asymmetrical, but S.G. is not bothered by this and is not interested in having a corrective surgery at this time.