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PRS GLOBAL OPEN

LETTER TO THE EDITOR

Reply to "The Limitations of Periareolar Mammaplasty"

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Dear Editor,

We read with great interest the letter to the editor entitled "The Limitations of Periareolar Mammaplasty" recently published by E. Swanson.[1]

We would like to thank him for opening the debate that is currently taking place in breast surgery, between standard and on-demand measurements in breast surgical procedures. In the following paragraphs, we would like to highlight some aspects of our previously published article and let the readers know why we consider the periareolar approach a valid technique for multiple breast conditions.[2]

- In our original article, we have specified that the periareolar technique is not suitable for every breast cone or breast tissue quality but needs to be tailored based on the patients' presentation.
- We are very committed to the vertical and T inverted techniques, which are routinely used by our group, but we are also convinced there are breast conditions that can be better addressed by a periareolar approach.
- The periareolar technique is not an easy surgery and requires a lot of experience.
- The starting position of the inframammary fold and its correction (if necessary, lower it) go hand in hand with the periareolar draw, just as in cases of stenotic breast, a detachment of all the retracting fibers is mandatory.
- For this reason, we have presented eccentric periareolar circles, and we use them to shorten the areola-inframammary fold distance in cases where it is lengthened by previous maneuvers.
- It must also be emphasized, as fundamental surgical elements, the complete incision of the dermis and the first deep round-block, because they are responsible for the projection of the central portion of the mammary cone, thus preventing both enlarged areola and bad scarring, avoiding areola flattening.
- These considerations derive from our experience in oncoplastic breast[3] surgery and correction of breast malformation, such as stenotic breasts.[4,5]
- Indeed, this technique best fits patients who have been correctly informed to the possibility to undergo further outpatient surgical revision of the nipple areola complex scars, if necessary.
- In our experience, it did not give rise to any legal disputes.
- The employment of this technique adheres to a different philosophy in plastic surgery, and we understand the difficulties associated with its use.
- We are convinced that the real innovation lies in the careful evaluation of the inframammary fold position, complete incision of the dermis, deep round-block suture, and eccentric oval circles (all these concepts were described in depth in our published article). We are aware that these concepts may be unfamiliar if not routinely employed, perhaps difficult to understand immediately by everyone.
- Regarding the photographs, we agree that they could be more standardized (we published them accordingly to the limit number) but, at the same time, we believe the results presented are enough to explain the key concepts of our approach.

We are proud to focus the attention on the periareolar approach a different way: despite being considered difficult by some parts, we are sure it can provide an extra tool in our field.

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DISCLOSURE

The authors have no financial interest to declare in relation to the content of this article.

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Received for publication November 15, 2021; accepted November 29, 2021.

Plast Reconstr Surg Glob Open 2022;10:e4067; doi: 10.1097/GOX.0000000000004067; Published online 24 January 2022.