

Four-step Augmentation Mastopexy: Lift and Augmentation at Single Time

Paul E. Chasan, MD; Cameron S. Francis, MD

We read with interest the recent article published in your journal, titled “Four-step Augmentation Mastopexy” by Ono and Karner.¹ This procedure is similar to our “reductive augmentation” technique,² the “combined breast reduction augmentation” technique described by Manero et al,³ and Swanson’s⁴ “breast reduction plus implants” technique. Taken together, these recent articles reflect a growing interest in combining elements of conventional breast reduction with implant-based breast augmentation to address the long-term shortcomings of conventional breast reduction, especially lack of upper pole fullness and descent of the inferior pole.

The major similarities between these techniques include placement of a sub-pectoral implant, sitting the patient up to make mastopexy markings, and then resecting the inferior pole breast tissue, usually in an “inverted-T” pattern. Generally, a superior medial pedicle is utilized, and often, undermining of the medial and lateral breast flaps is required. Overall, the goal is to effectively redistribute the apparent breast volume superiorly, using an implant to provide fullness at the upper pole, while resecting breast tissue at the lower pole.

There are some technical differences between each groups’ respective approaches. Notably, while we develop a dual-plane pocket for the implant, other groups either leave the lateral slip of the pectoralis major muscle intact (Ono and Karner¹) or maintain full muscular implant coverage (Manero et al³). Their rationale for more robust muscular coverage is that this provides better long-term maintenance of implant position. On this point, we diverge from the other groups conceptually.

It is our view that bottoming out after sub-pectoral augmentation with mastopexy in this patient population is less likely to result from implant descent than from a failure to adequately resect inferior pole breast tissue. With sufficient inferior pole tissue resection, the forces acting on the implant differ little from a primary breast augmentation.

For our primary reductive augmentation group, the average resection of breast tissue was 255 g per side versus 162 g in Ono and Karner’s 4-step augmentation mastopexy study, while our average implant size was 326 versus 334 cc in their series. Other technical differences

between our reductive augmentation procedure and the 4-step augmentation mastopexy include our use of smooth, round silicone implants versus their use of textured silicone implants. Although they place the final implant before tissue resection, we place an implant sizer and defer final implant selection until we have performed a primary mastopexy, tissue resection, and a secondary refining tailor-tack mastopexy. We believe that following the larger resections, there is a dramatic difference in the appearance of the breast, which often dictates a different shape and/or style of the implant than the one initially selected.

In conclusion, plastic surgery represents the surgical nexus between esthetic form and functional anatomy. For those patients with macromastia who desire long-lasting superior pole fullness, we need not be dogmatic about the primacy of function at the expense of esthetics. The data emerging from these 4 independent series demonstrate that, with technical refinement, simultaneous implant placement in the setting of breast reduction can be appropriately applied in a reproducible fashion with consistent long-term results. We congratulate the other authors not only for taking on this difficult challenge but also for achieving excellent results with low complication rates.

Paul E. Chasan, MD

Ranch and Coast Plastic Surgery
1431 Camino Del Mar
Del Mar, CA 92014
E-mail: pchasan@drchasan.com

DISCLOSURE

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

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From Ranch and Coast Plastic Surgery, Del Mar, Calif.

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