

PROCEDURE NOTES

Breast Reduction

Breasts develop during puberty and thereafter gradually decrease in size, especially after pregnancy. By menopause, as a result of tissue loss, they can look empty and saggy. In rare cases, in early life, breasts can continue to grow to a very large size. This may require early surgical intervention, and in extreme cases, more than one operation may be necessary. The condition is called virginal hypertrophy or enlargement. Similar problems can occur during the menopause, especially when HRT (hormone replacement therapy) is used. In both cases, the condition can become distressing both physically and psychologically. In most cases however, the woman has always had very large breasts, such as a DD cup, and gradually they become a burden, preventing her from participating in sporting activities, and wearing clothes of choice. The result of heavy breasts may also cause the patient to get deep shoulder strap marks from her bra, the skin can become irritable under the breast fold, and the shoulders become rounded and aching. It is not unusual to develop neck ache.

Being overweight can accentuate the problem, and any woman contemplating breast reduction should lose a significant amount of weight before undergoing such surgery. This will make the surgery easier, safer and the outcome is likely to be better. Breast reduction aims at achieving two things; reduction in the volume of the breast and tightening of the skin, with repositioning of the nipple, because large breasts are invariably saggy.

There are many different types of breast reduction and every surgeon has his or her favourite technique. From the patient's point of view, the most important aspect is the scar and its extent. Most techniques produce an anchor-shaped scar, i.e. a scar circumscribing the areola of the nipple and then vertically down to the breast's fold, where it joins a horizontal scar in the breast fold. The disadvantage of this scar is that it is quite long and its inner, or cleavage aspect can be visible.

Other techniques attempt to try to reduce the size of the scar as much as possible by omitting the inner or cleavage part of the scar. The scar then becomes L or J shaped. Not all surgeons are prepared to use these techniques for a variety of reasons.

Breast reduction is usually carried out under general anaesthesia, and if the breasts are very large, the surgeon may elect to cross-match blood in the event that there may be significant blood loss. Prior to surgery, the new site of the nipple is marked, and the rest of the marking is carried out in theatre. Before removing breast tissue, the surgeon has to preserve the blood supply to the

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nipple, so that it can be moved to its new position. The appropriate amount of skin and breast tissue is removed to fashion a new breast shape, and the wounds are then closed. Attention has to be paid to symmetry by measuring the amount of breast tissue removed. However, most breasts are unequal in size before surgery, and it is not possible to make both breasts identical in shape and size.

Drains are usually left inside the wound to drain away any excess blood, the dressings are applied, and the breasts are strapped. After 24-48 hrs, the drains, dressings, and the strapping may be removed. The sutures are removed 7-10 days later.

As in all surgical procedures, some complications may occur. Most are uncommon and usually occur in the early post-operative period.

1. Bleeding: This usually occurs during the first 24 hours after surgery and results in the accumulation of blood in the breast pocket. The patient may have to be taken back to theatre to remove the excess blood and stop any bleeding if necessary. This should have no untoward consequence on healing and the final result.

2. Infection: This becomes apparent within a week of surgery, usually at the time of suture removal. This may necessitate a course of antibiotics and drainage of the wound.

3. Scars: All patients form different scars, and some are prone to hypertrophic or keloid scarring, which are itchy, raised, red, and may be uncomfortable. The simplest treatment may be by steroid injections into the scar, or by applying topical silicone sheeting. In some cases revision of the scars may be necessary.

4. Nipple sensation and viability: In approximately 50% of patients sensation to the nipple may be lost or reduced, depending on the type of operation performed. There is no remedy for this outcome, which is inherent to the procedure.

5. Breast symmetry: It is not possible to produce perfectly symmetrical breasts, particularly if they were asymmetrical and very large before surgery. If there is a significant discrepancy, this can be corrected by removing more tissue from the larger breast.

6. Nipple necrosis: Blood supply, just as nerve supply, can be affected by surgery. This is more likely to happen in heavy smokers, obese patients, or if post-operative swelling is excessive. This usually affects only a small part of the

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nipple and will heal with careful wound management. The scar may have to be revised after 6-12 months.

As in all surgery it is essential to see a surgeon who will be able to tell you whether your problem can be remedied by surgery, and what the risks are. Thereafter you will be in a position to decide whether you should go ahead or not.