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# Mastopexy and Breast Reduction after massive weight loss

- MWL is defined as a loss of 50% of more of the excess weight in the morbidly obese.
- Relapse rates
- We often mean “impressive weight loss”

# Mastopexy goals

- Reshape the breast into a youthful cone
- Elevate the NAC to the level of the IMF
- Restore volume in  the upper pole where it has emptied out.
- Reduce overhang and skin on skin contact
- Reduce the embarrassment of breasts swinging and lateralizing excessively and slipping out of a bra
- (going without a bra)

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# Breast Reduction goals

- Reduce Pain in the shoulders and the back
- Reduce the embarrassment of prominent breasts
- Reshape the breast into a youthful cone
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- Reduce overhang and skin on skin contact
- Reduce the embarrassment of breasts swinging and lateralizing excessively and slipping out of a bra
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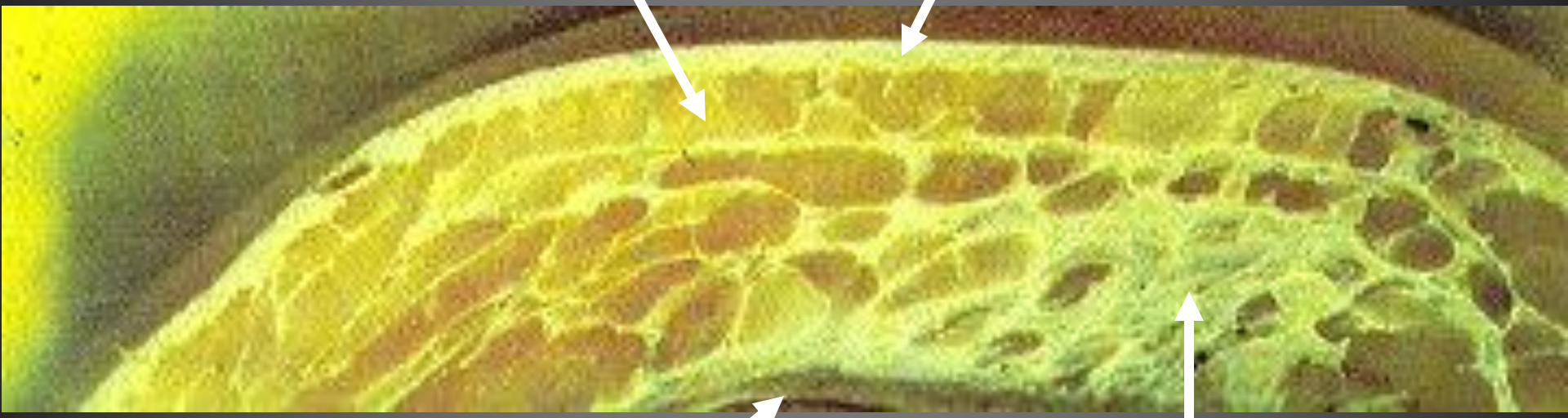
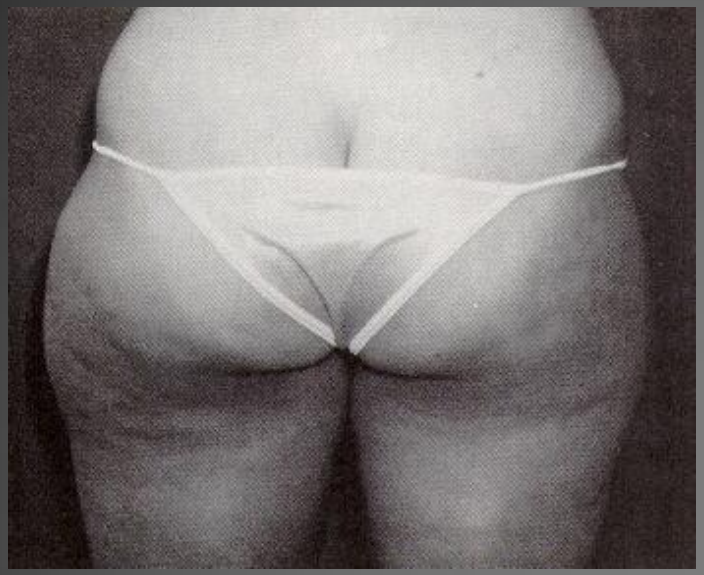
# Expectations

- Jewel:  Wishes vs Tissues.
- Gault: PPP Syndrome
- Hall-Findlay: High Breasted and Low Breasted
- Emmett: Information before the operation is explanation, information after the operation is excuse.

# Structure

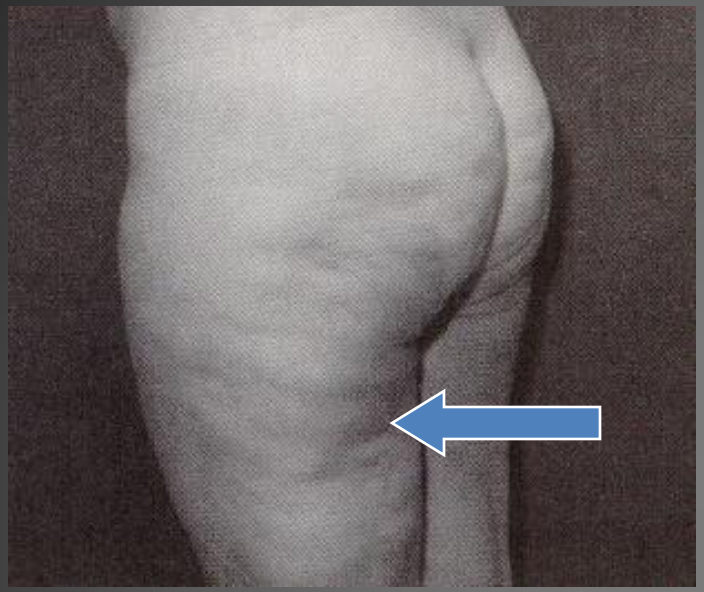



After Lockwood



Primary Cellulite

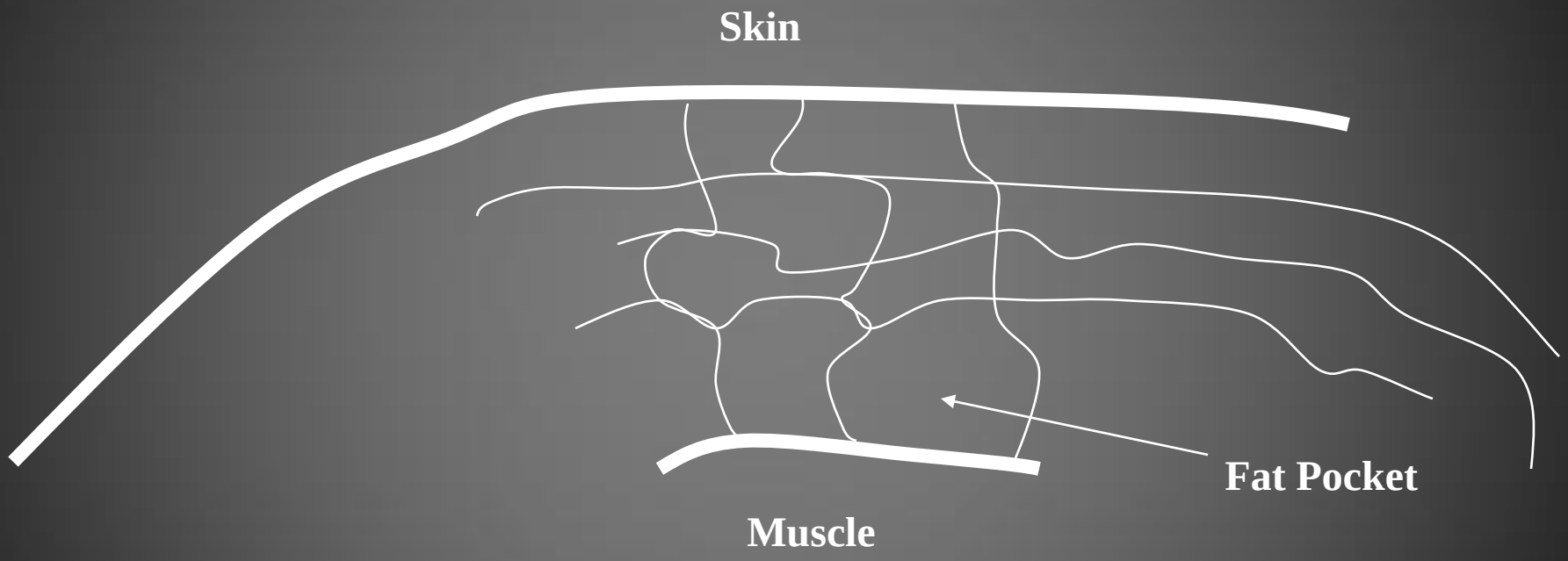
of youth

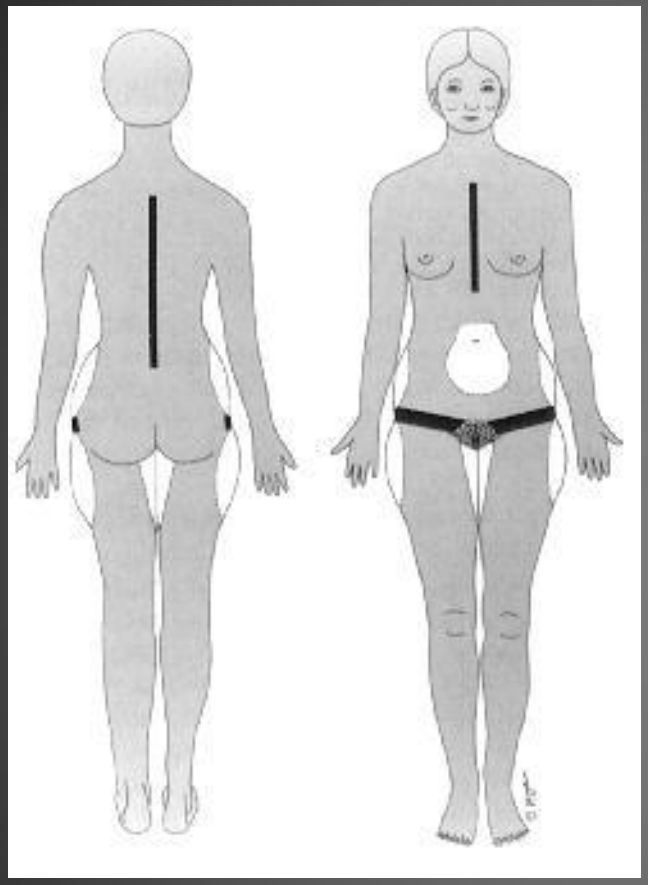


Secondary Cellulite

of laxity

# Radial and Tangential fibres





**Female**

# Zones of Adherence

Dense collections of fascia form a band or skin “ligament”

Males have many more radial fibres for support

# Fascial support

- Cooper's ligaments are likely to be a part of the SFS as the breast is a modified sweat gland.
- Cooper's ligaments can't be restored or reconstituted once overstretched.
- IMF is a fascial condensation and is seen as the indent in a double bubble deformity or the indentation in a tubular breast reconstruction.

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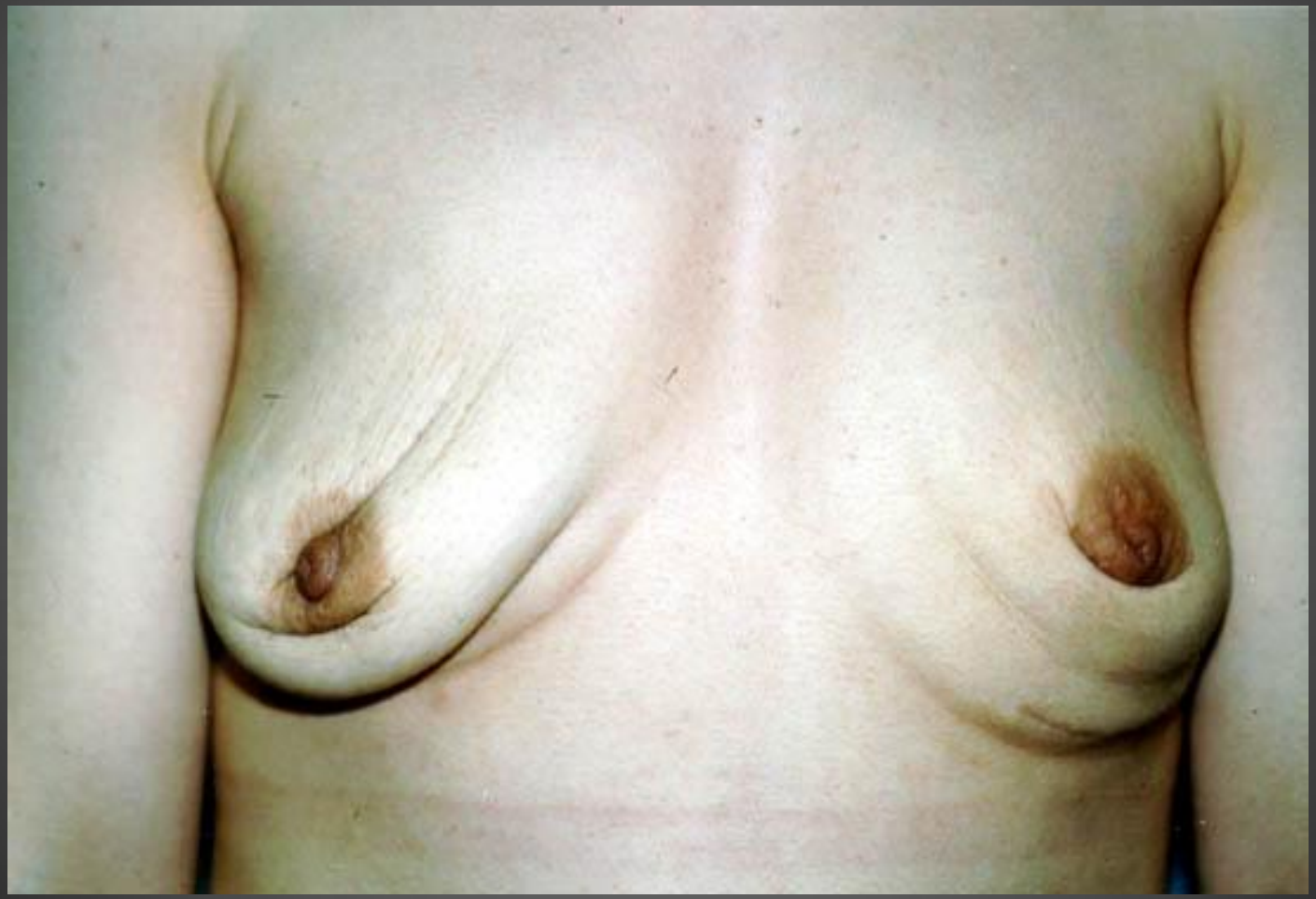
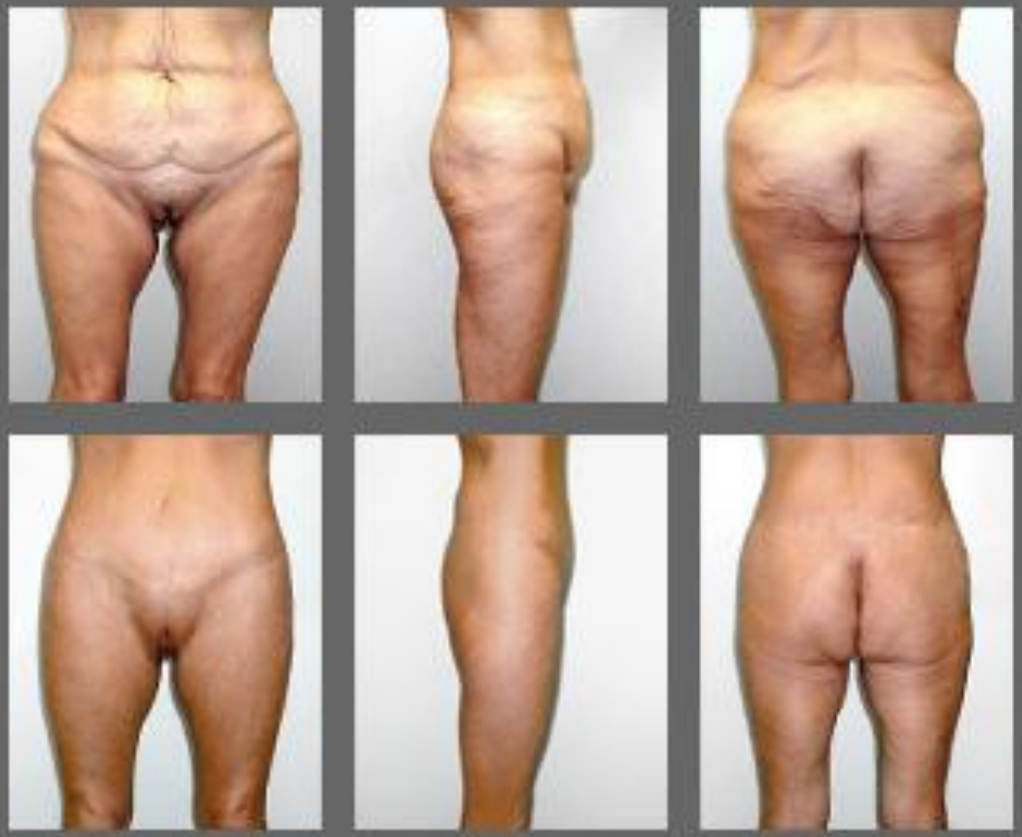


# Capella

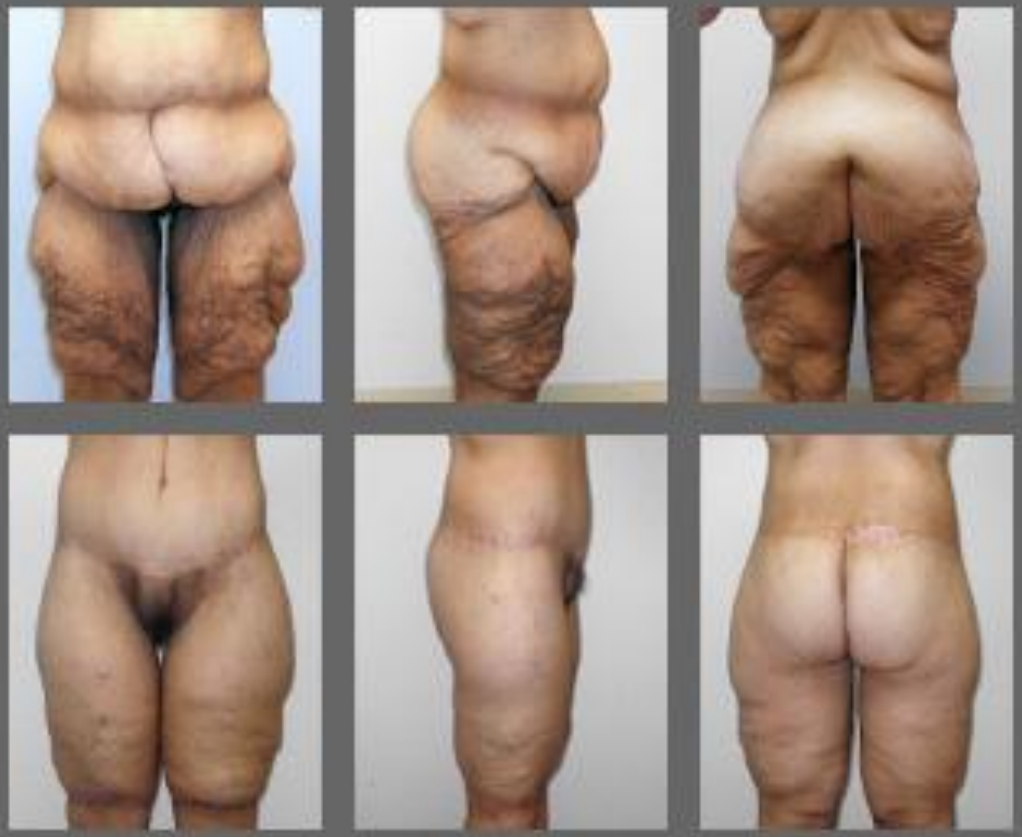
- Despite consistent techniques, outcomes following postbariatric body contouring can vary significantly in both aesthetics and complication rates. The most important variables appear to be body mass index (BMI) at presentation, the highest BMI before weight loss, morphology, age and history of smoking (and concomitant disease: hypertension, diabetes, vascular disease, etc)

# BMI 39 -21 LOSS OF 53 KG



AFTER CAPELLA

# BMI 64 TO 25 LOSS OF 89 KG



AFTER CAPELLA

# Precautions

- Smoking
- Weight Loss before booking
- BP control
- DVT prophylaxis

# Breast Reduction

- Physical symptoms bring the patient along but they always have an expectation of an aesthetic improvement whatever they tell you

# Inferior Pedicle

- Safest technique for Sensation, viability of NAC and breastfeeding
- Better for removing higher volumes of tissue
- Suffers from boxy shape and emptying of the upper pole
- (Bottoming out)

# Supero-medial pedicle

- Better shape and better upper pole fill
- Poorer rates of nipple necrosis, breast feeding and nipple sensation
- Quicker and less blood loss
- Less advantage after MWL because a Wise pattern is required and the pedicle may be too long to be safe.
- Better for a subsquent augmentation.

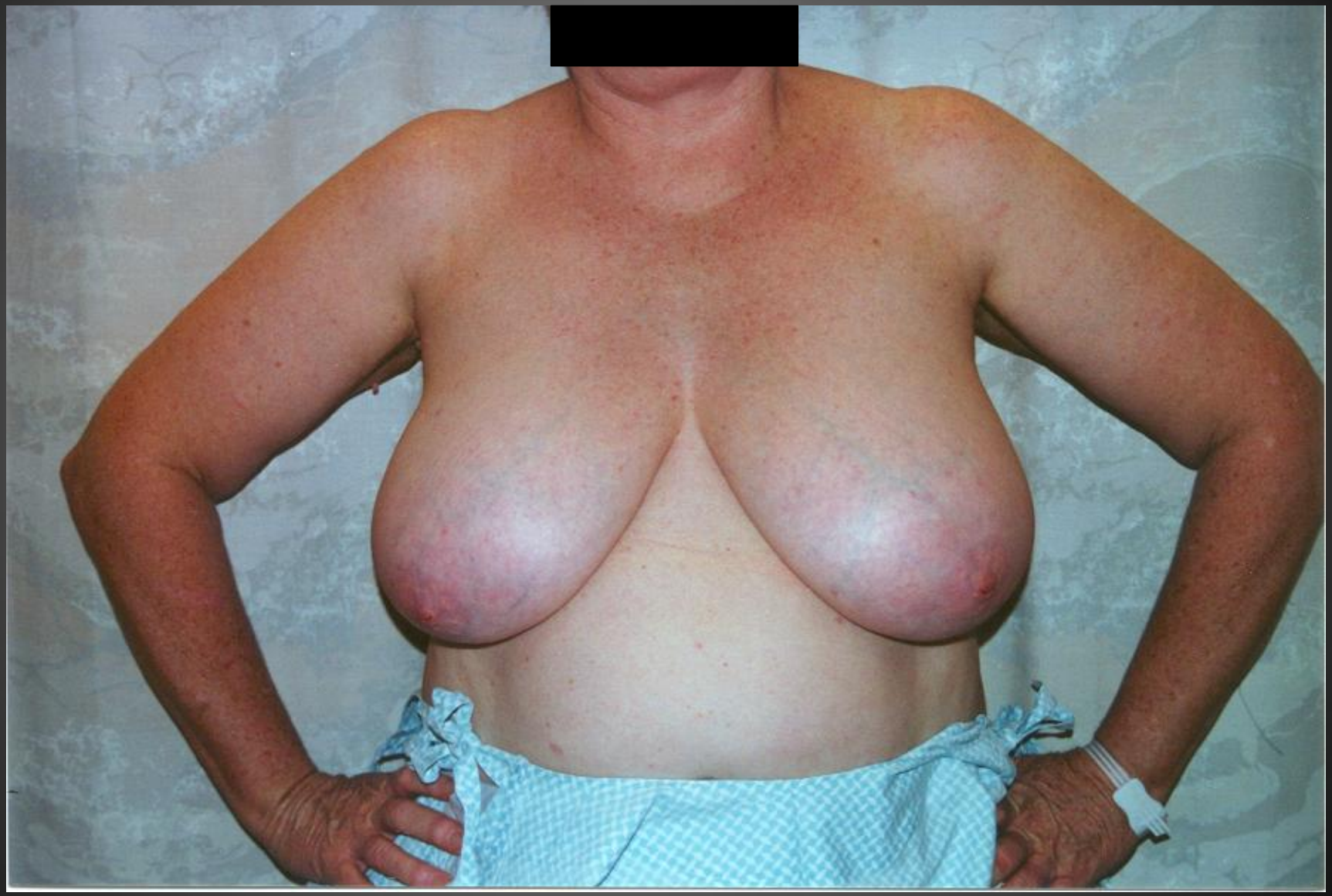
# Free Nipple graft

- Largely outdated technique
- Appropriate for the elderly and infirm

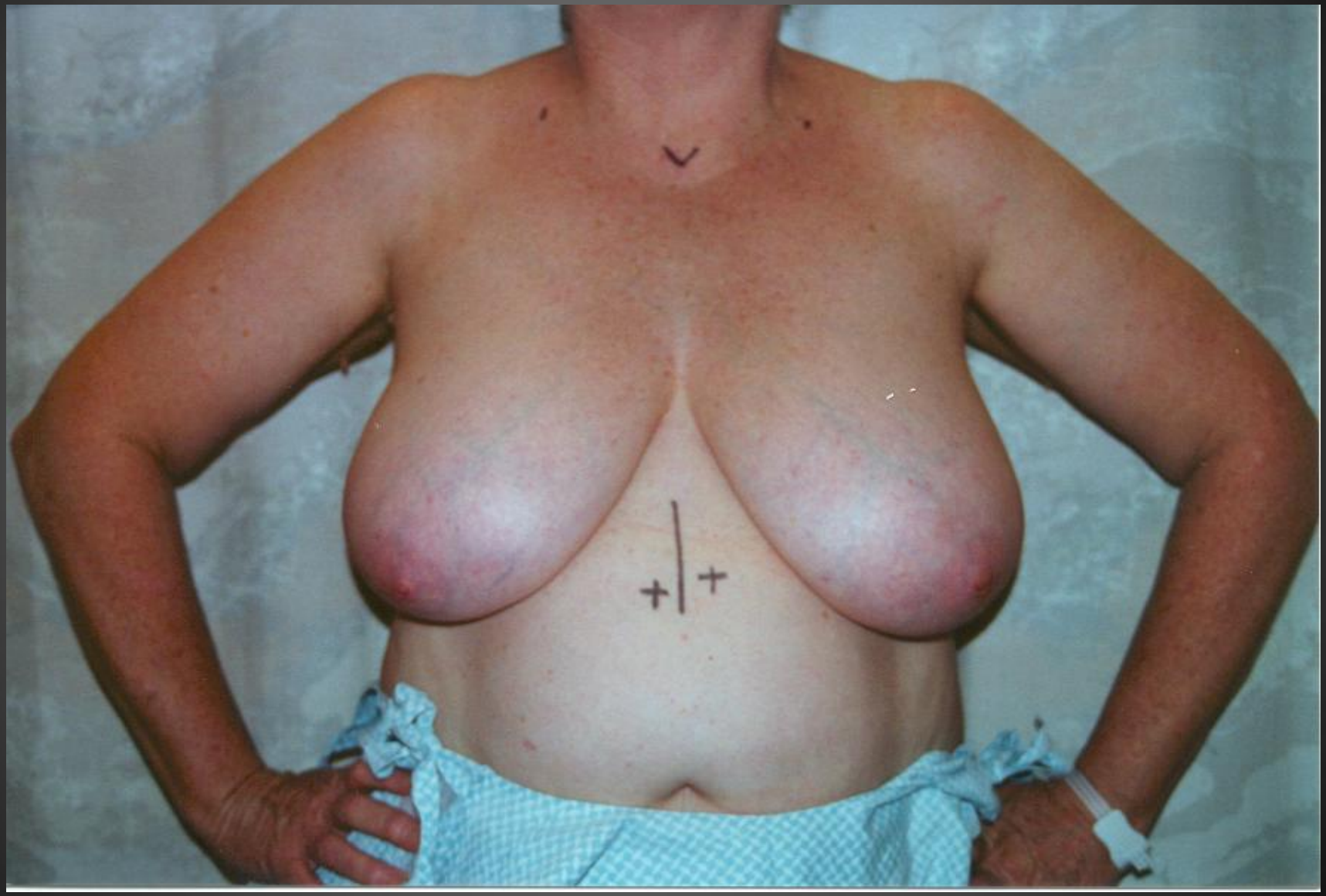
# Shaping an inferior pedicle reduction

- Upper pole fullness is a universal desire
- Minimize the pedicle and maximize the tissue left in the cleavage and upper poles
- Thin down the lateral flap

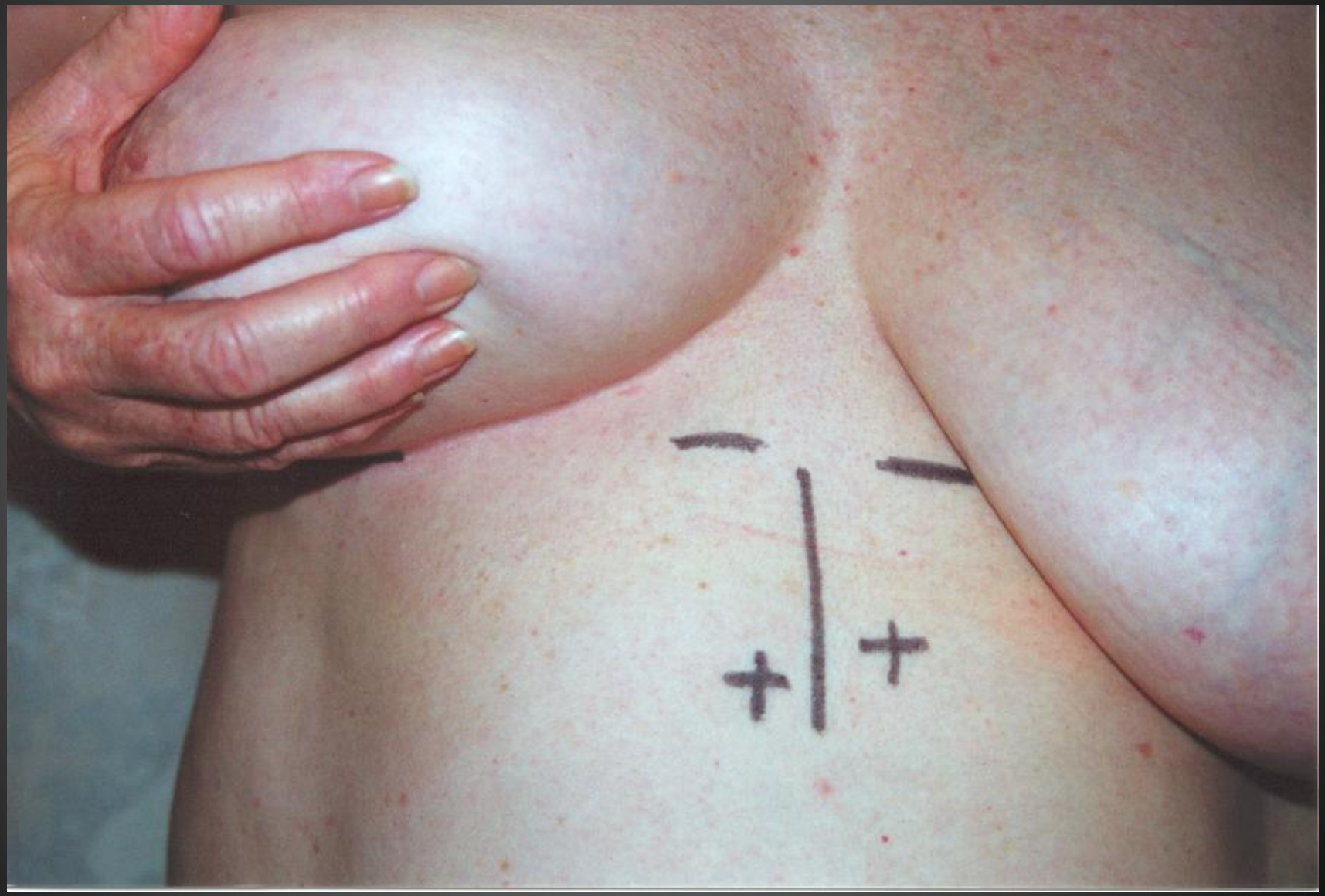
# Markings: the key to the good result



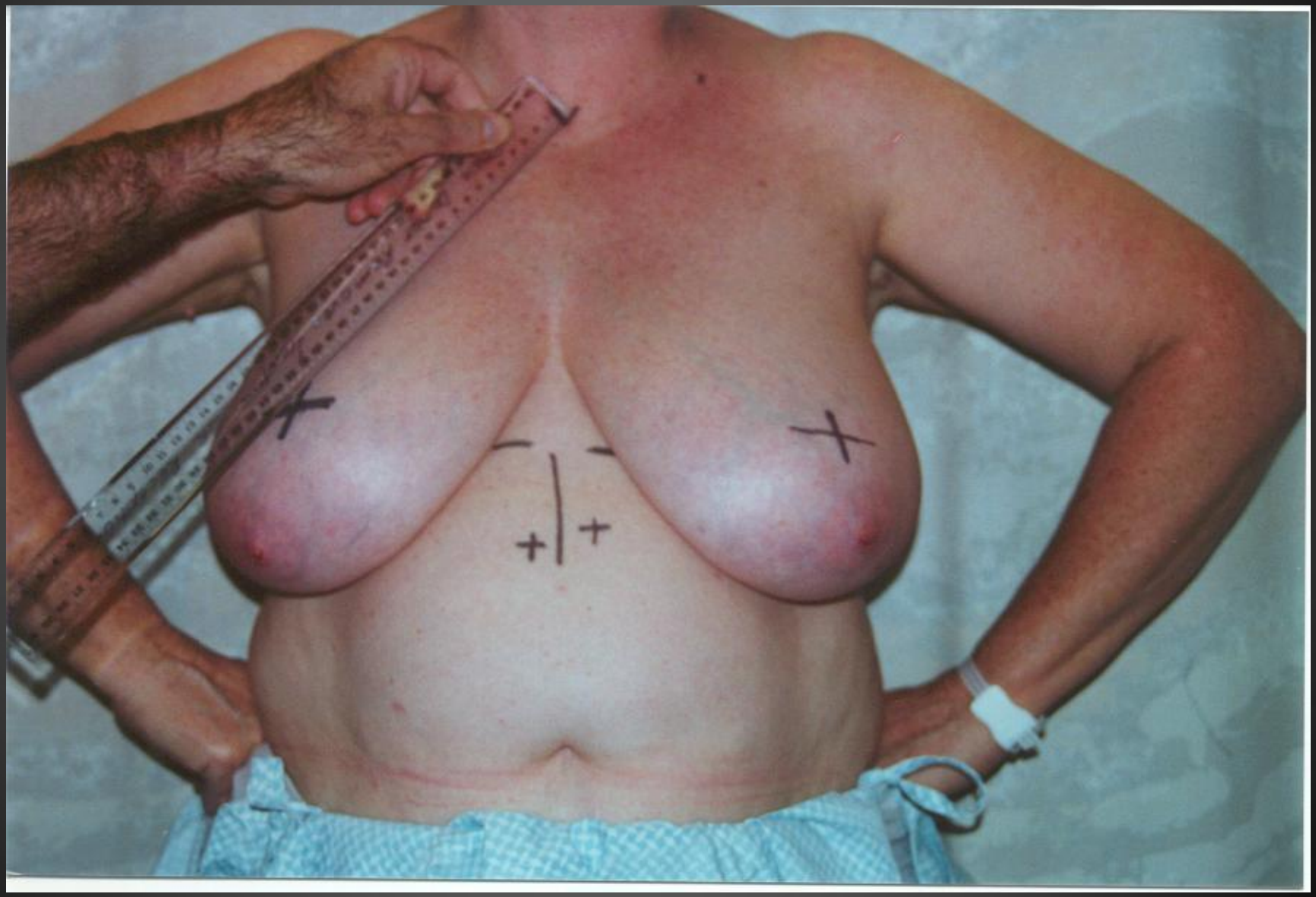
# Midline and Nipple height

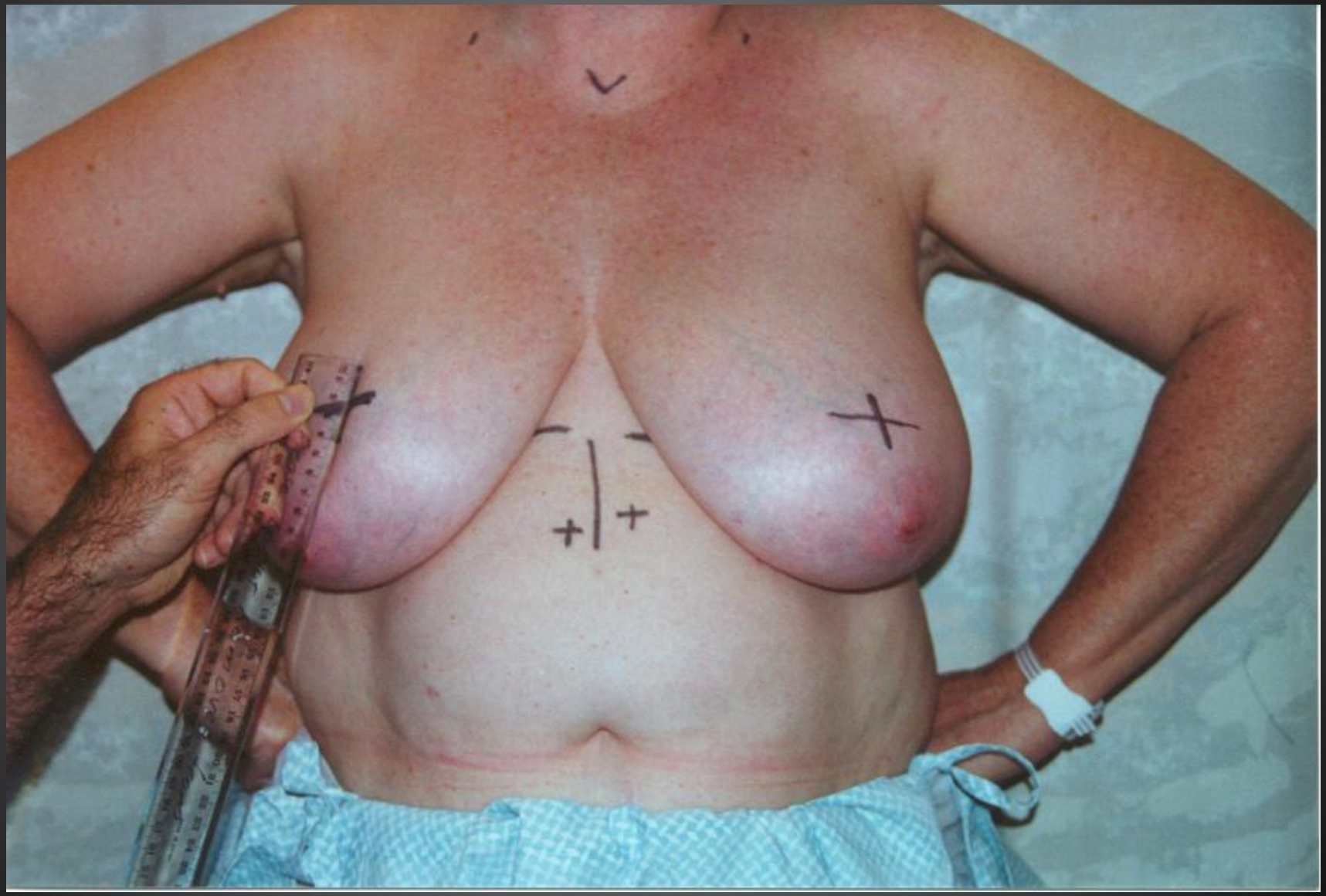


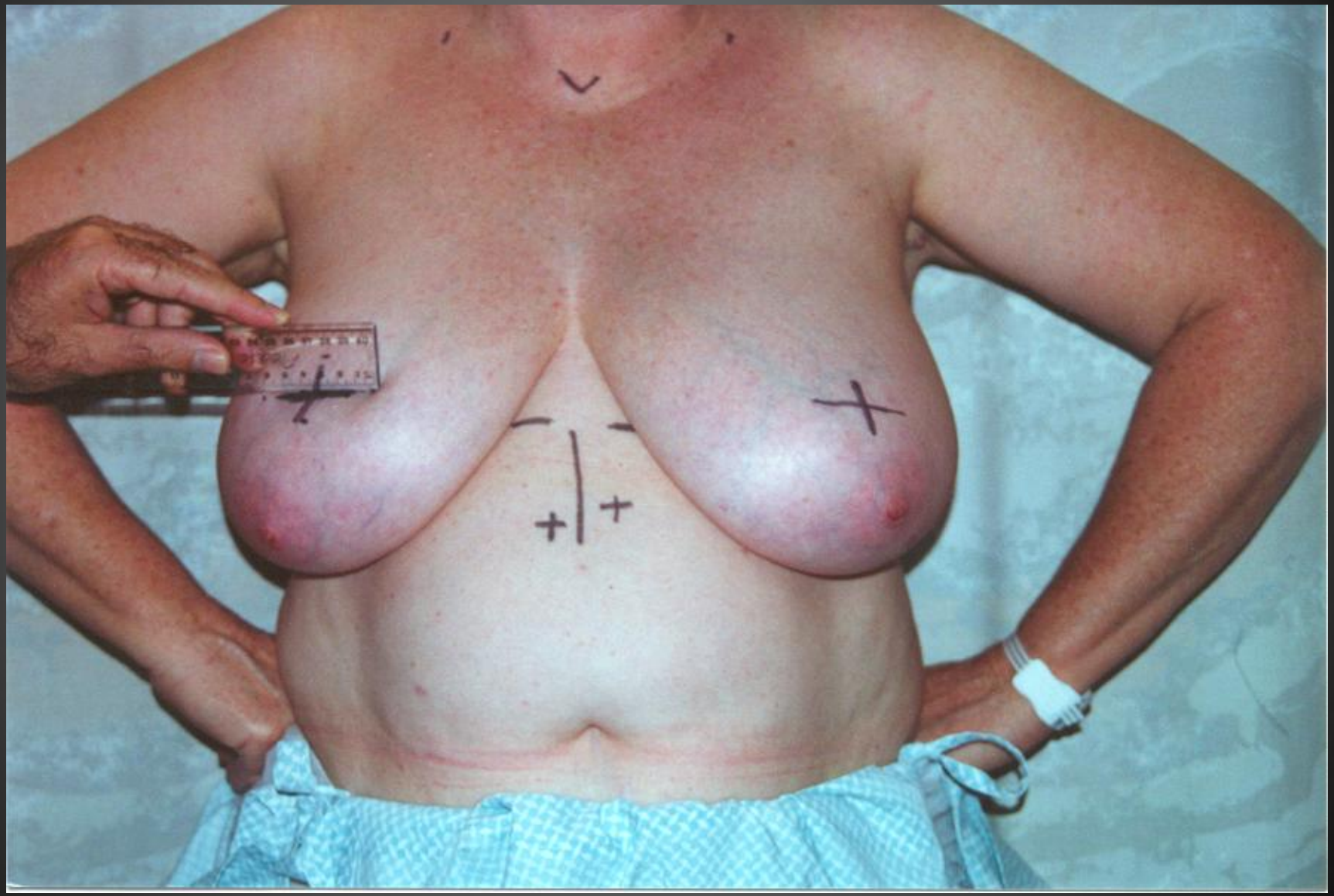
# IMF



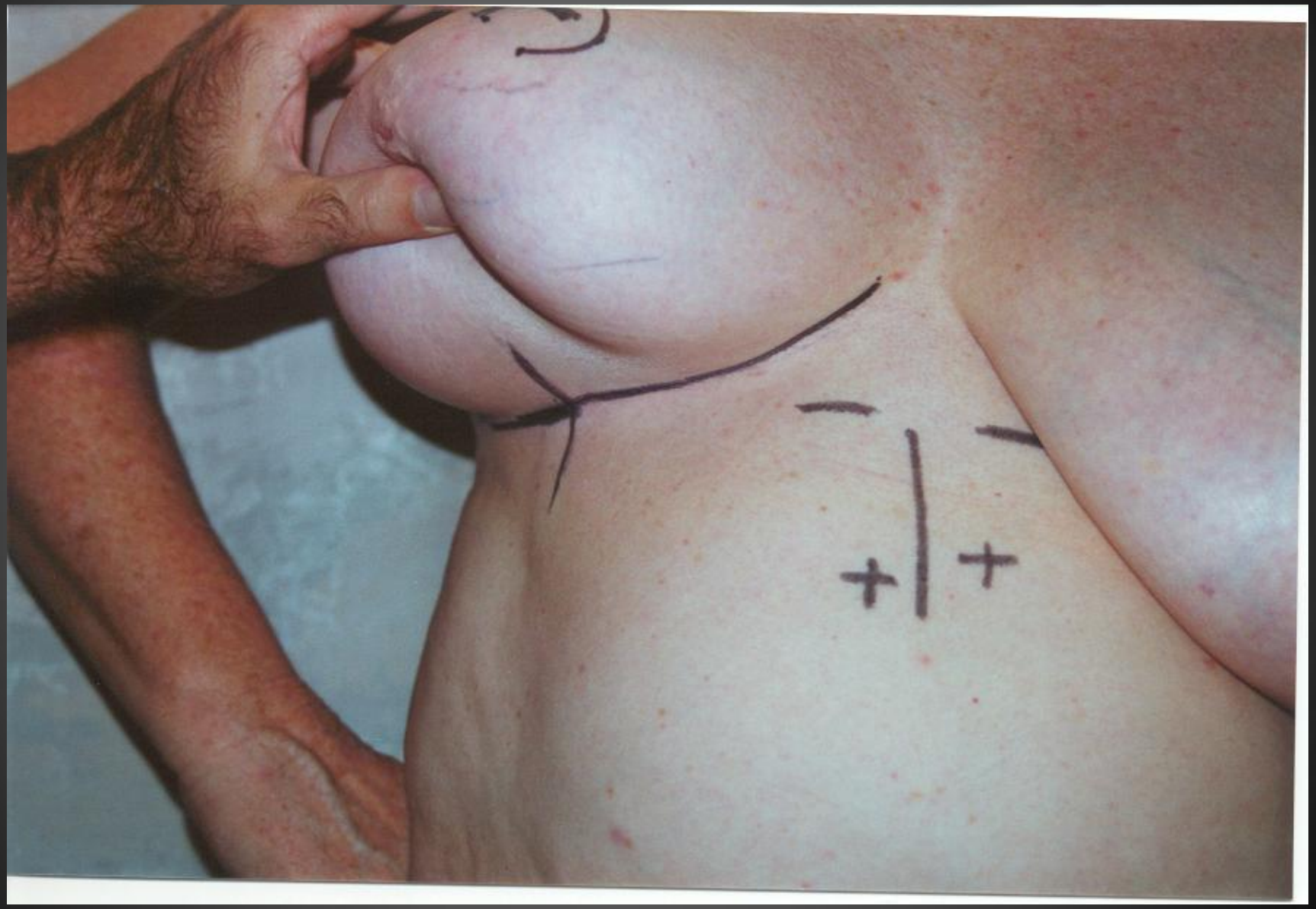
Check that the top of the nipple is not higher than 21cm

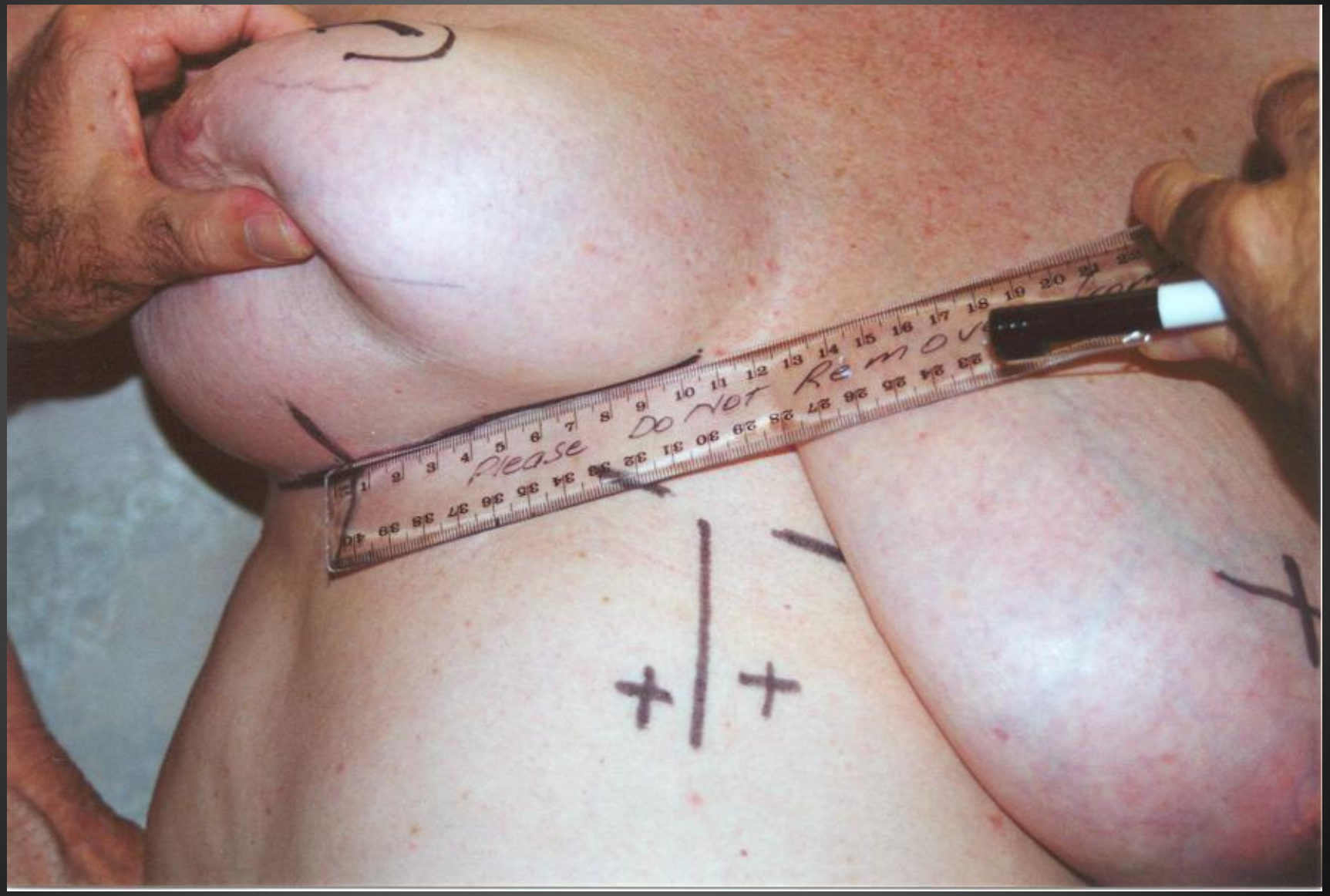


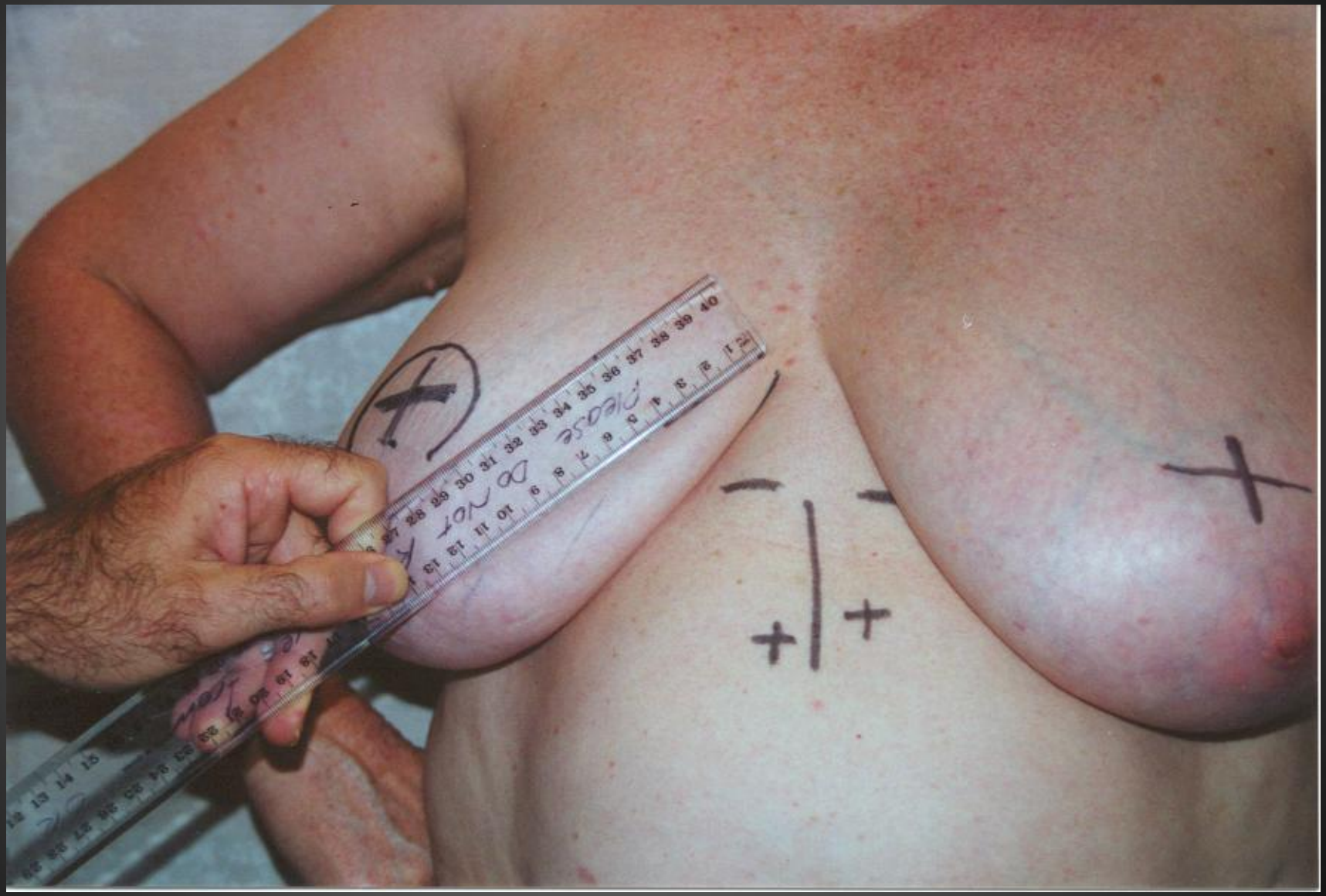


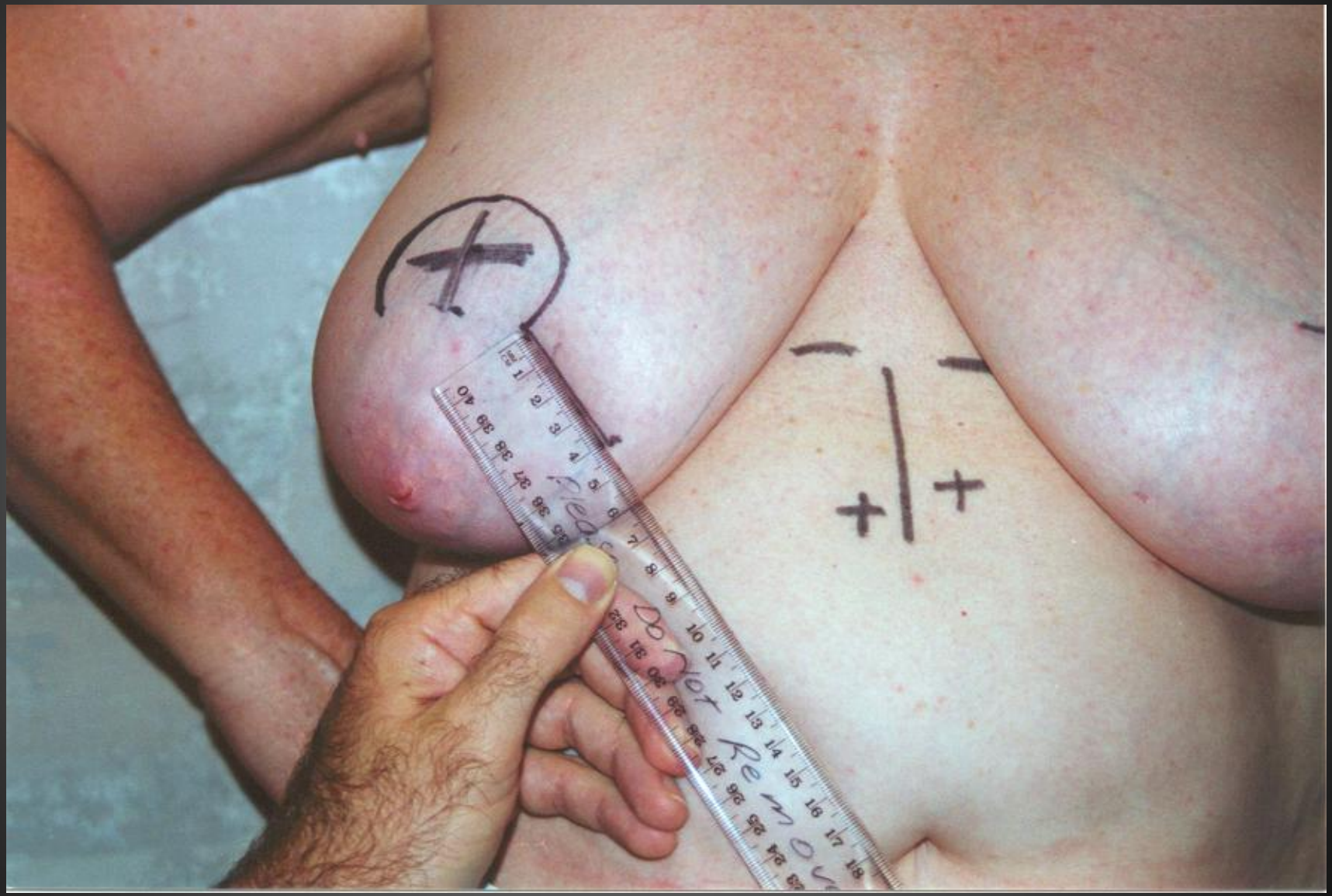


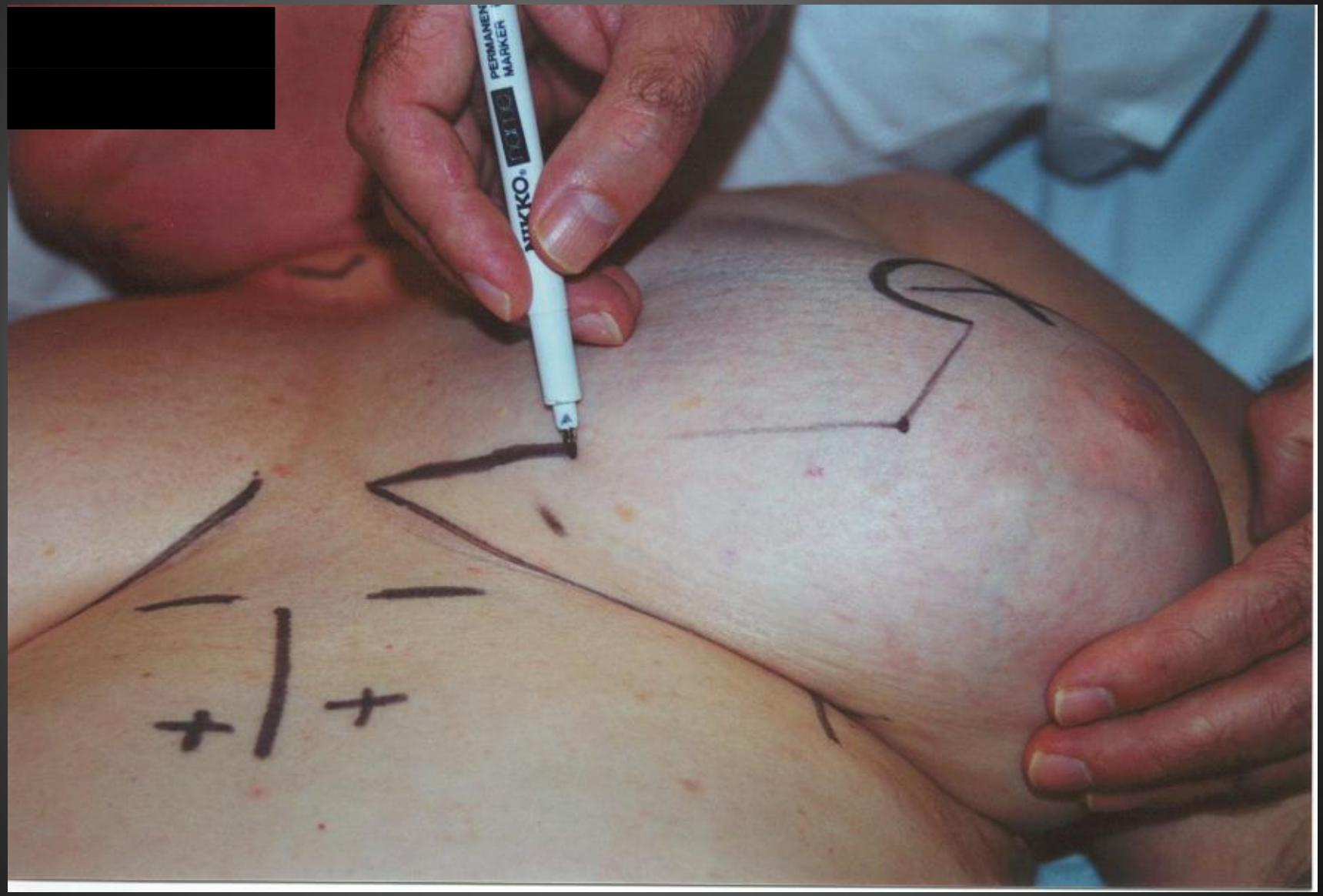
# Midline and inferior limbs

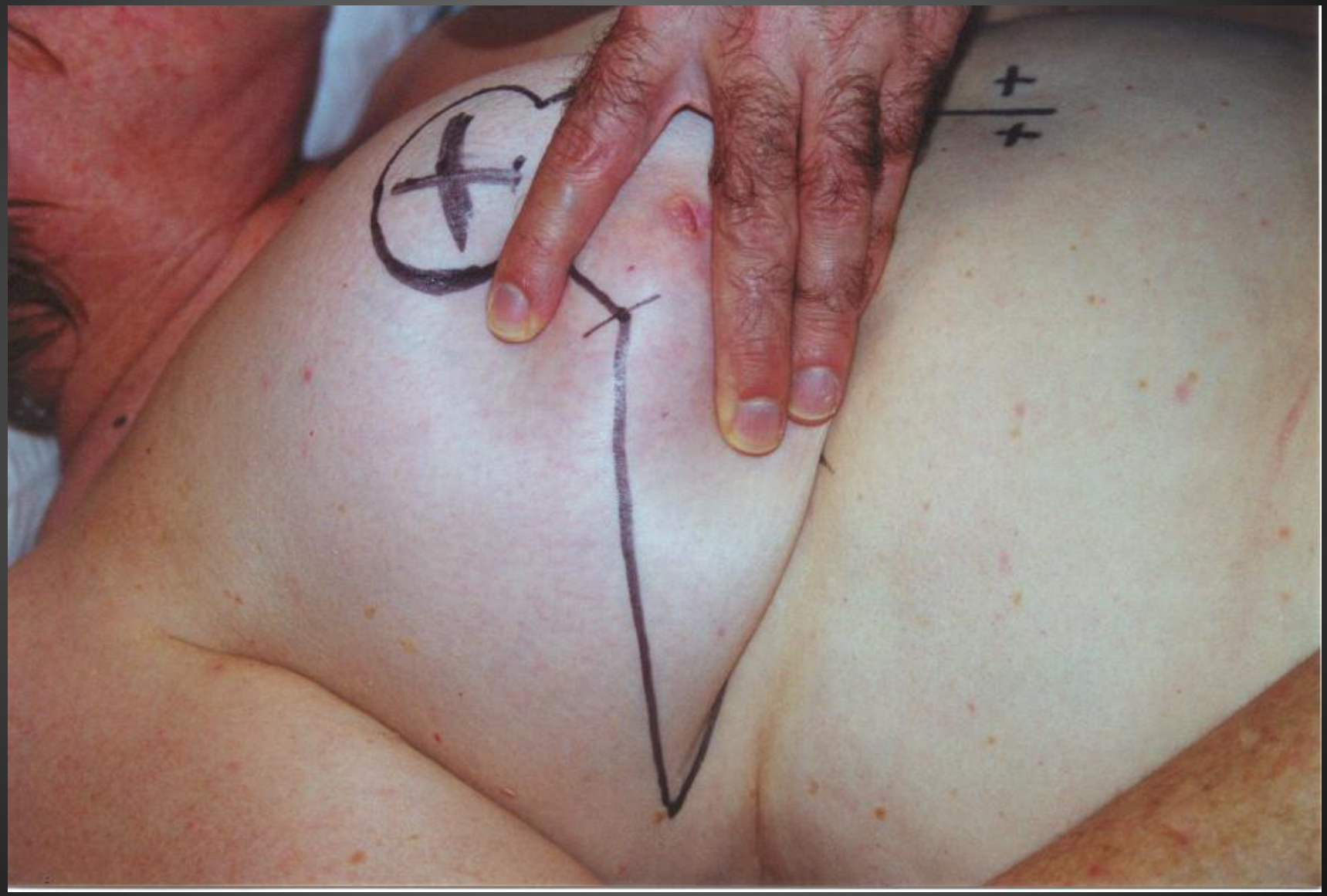



Please Do Not Remove



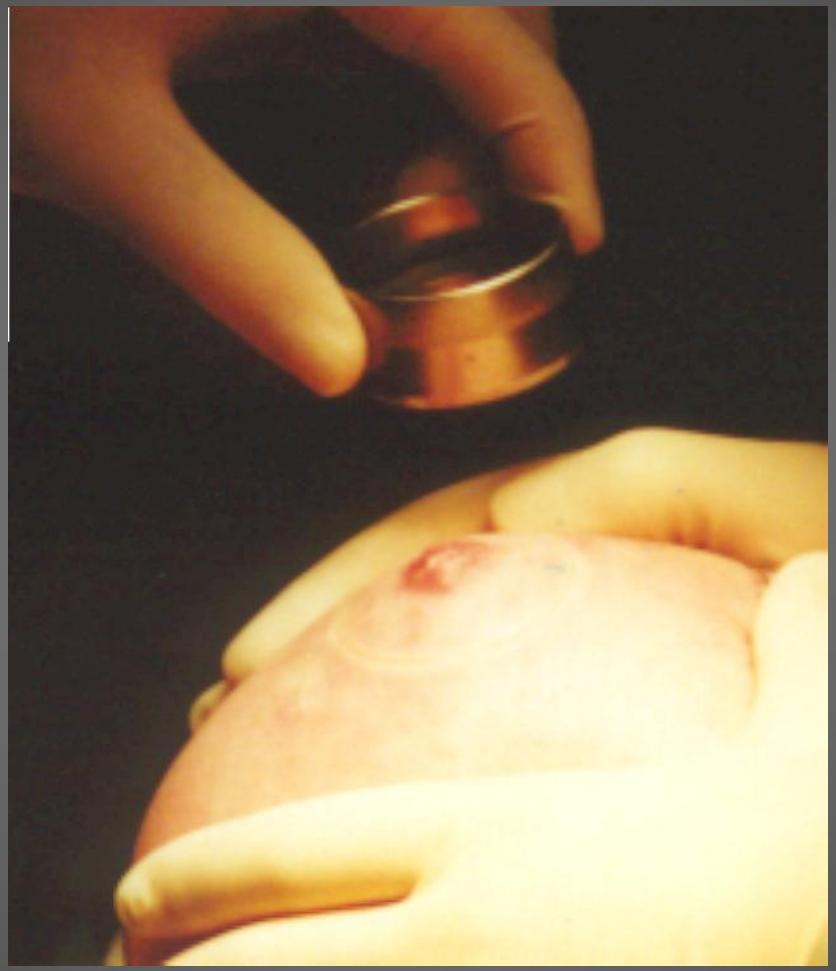



PERMANENT MARKER
MAKKO

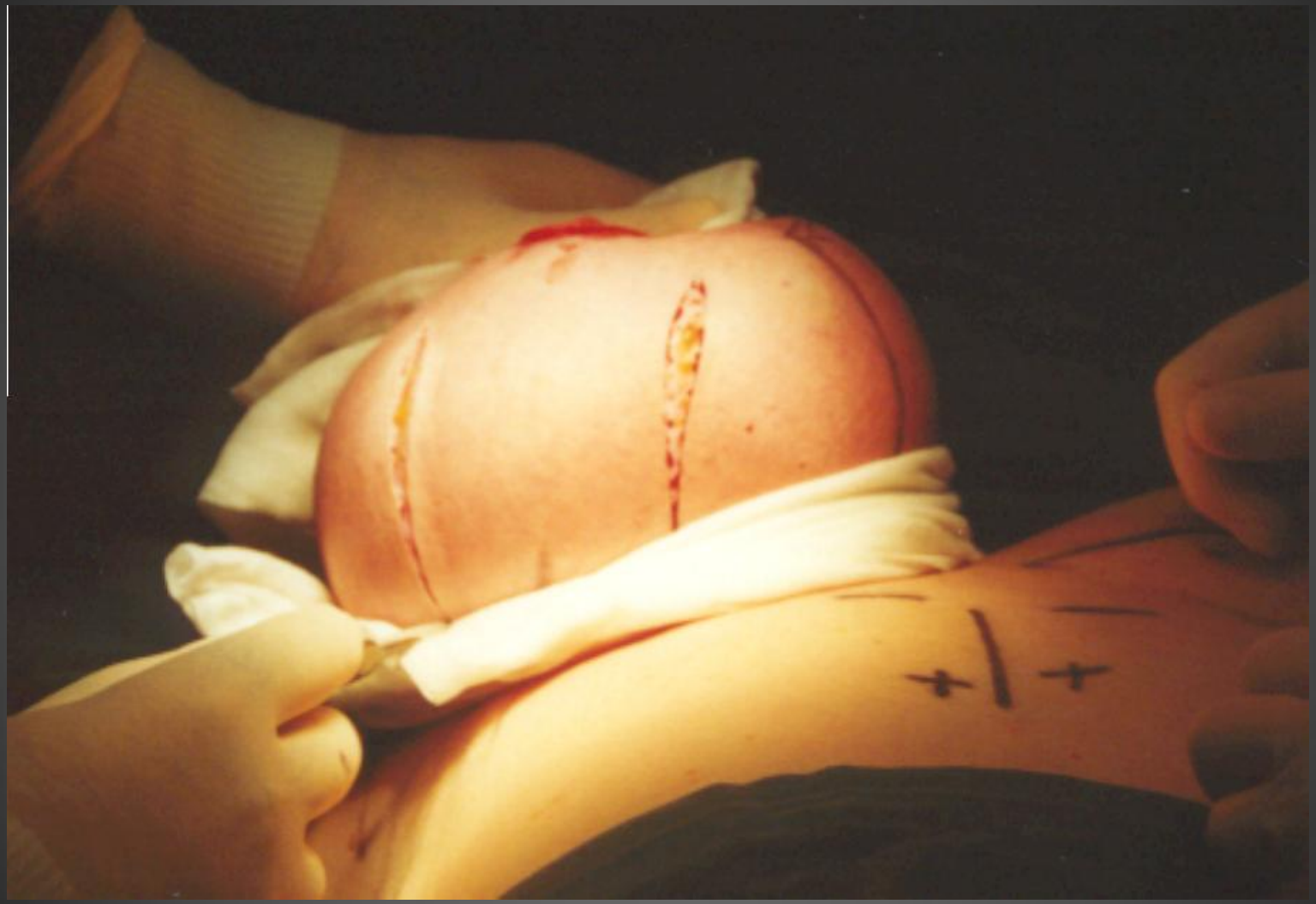


# Infiltrate

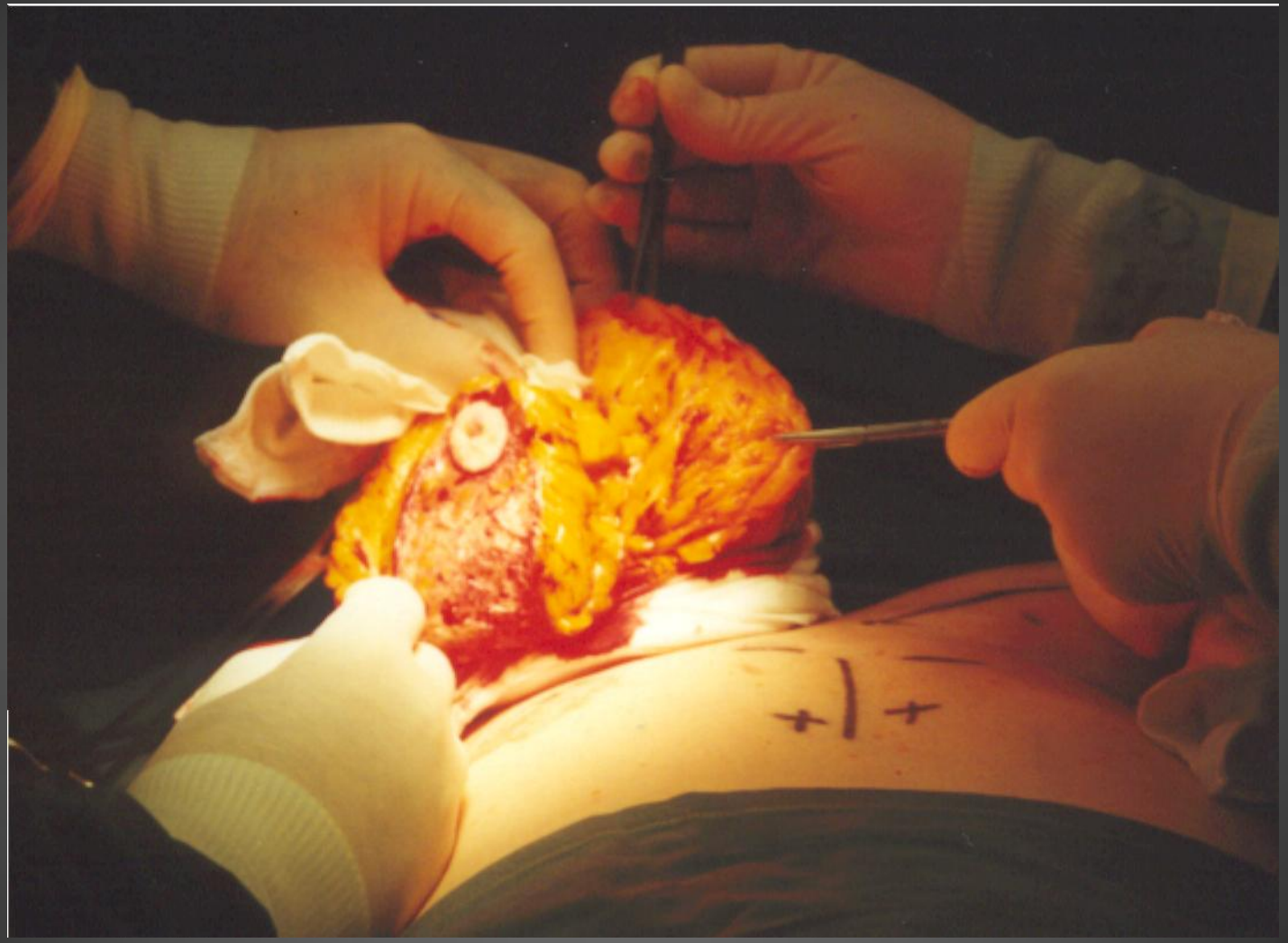
- Analgaesia
- Haemostasis



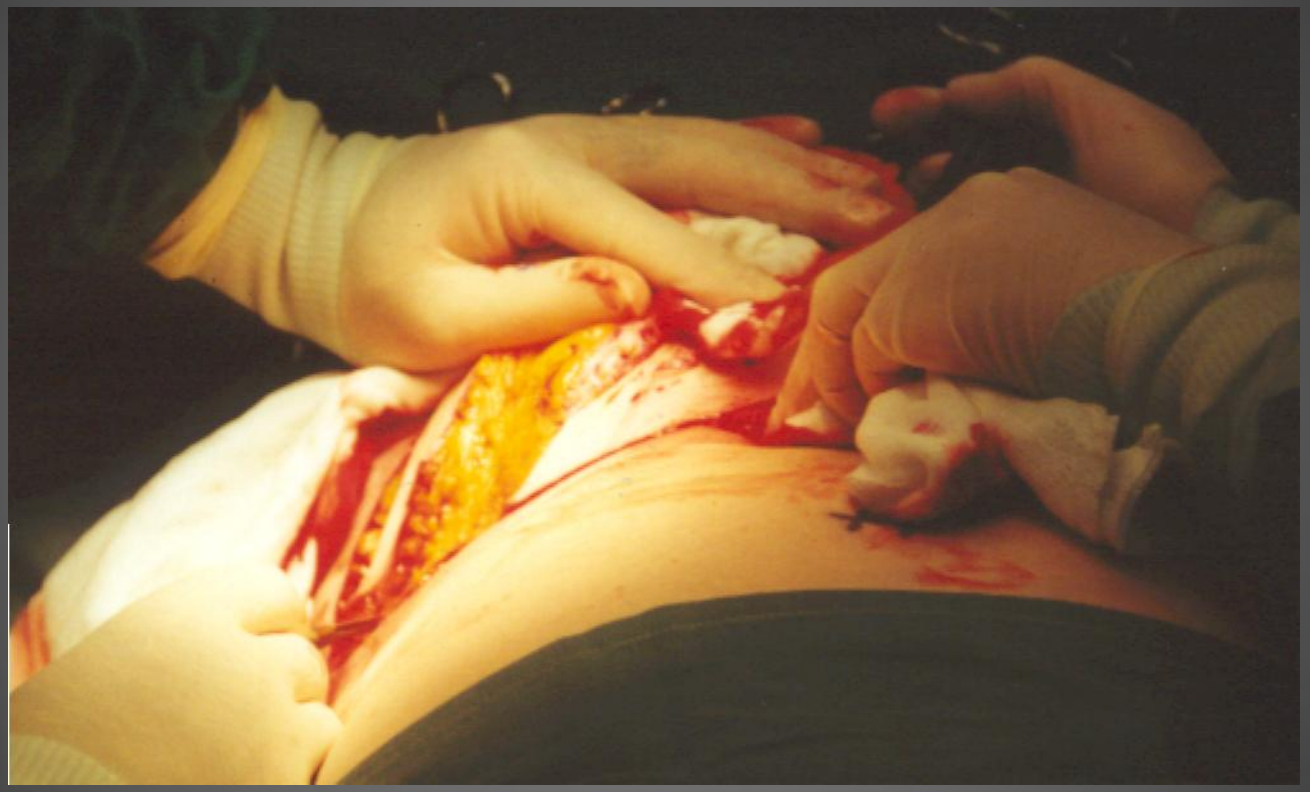
Use a Tourniquet for tension on the skin



Leave the dermis for healing

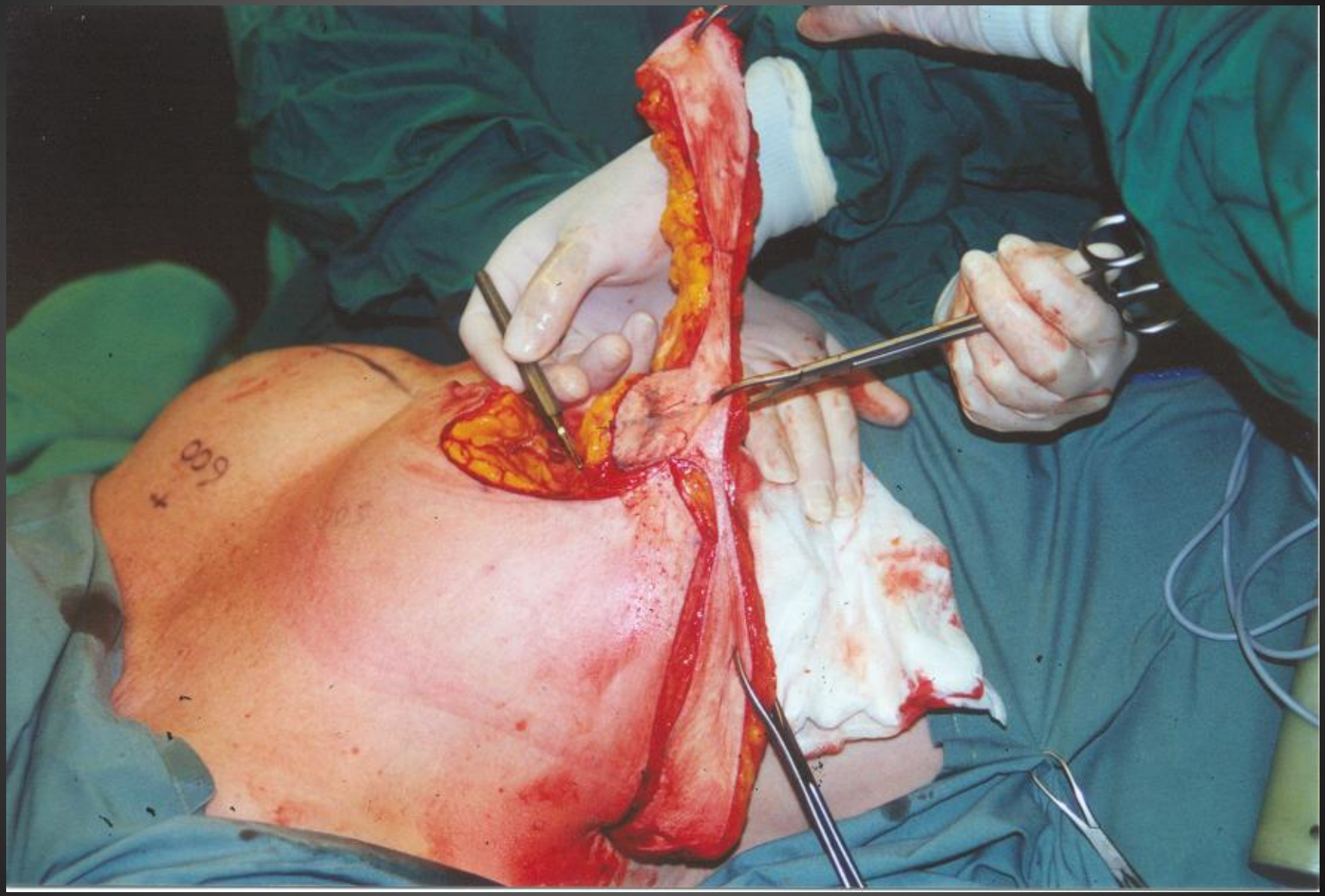


Use Mohnihan’s to hold breast away while you carve a neuro-vascular pedicle for the nipple

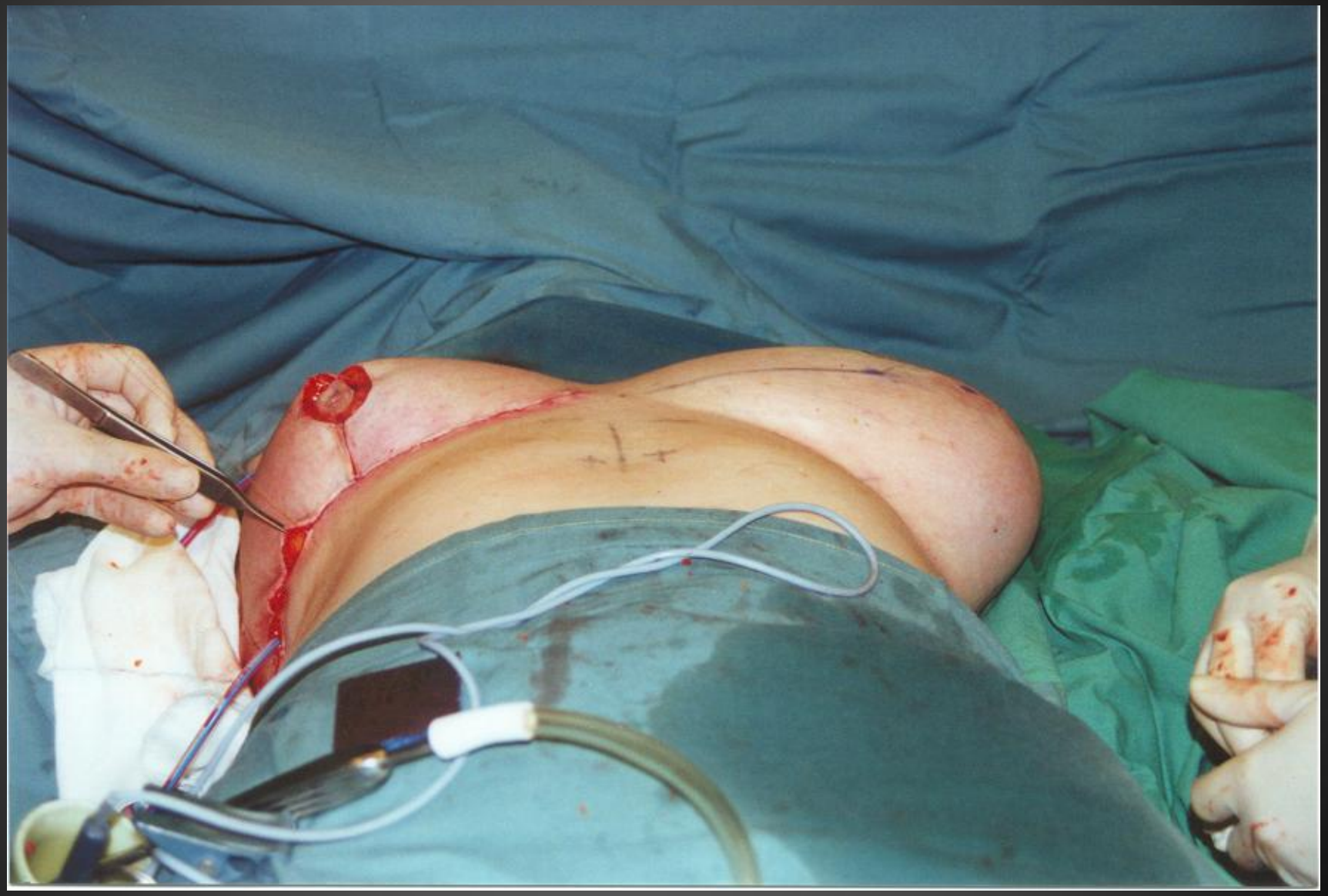


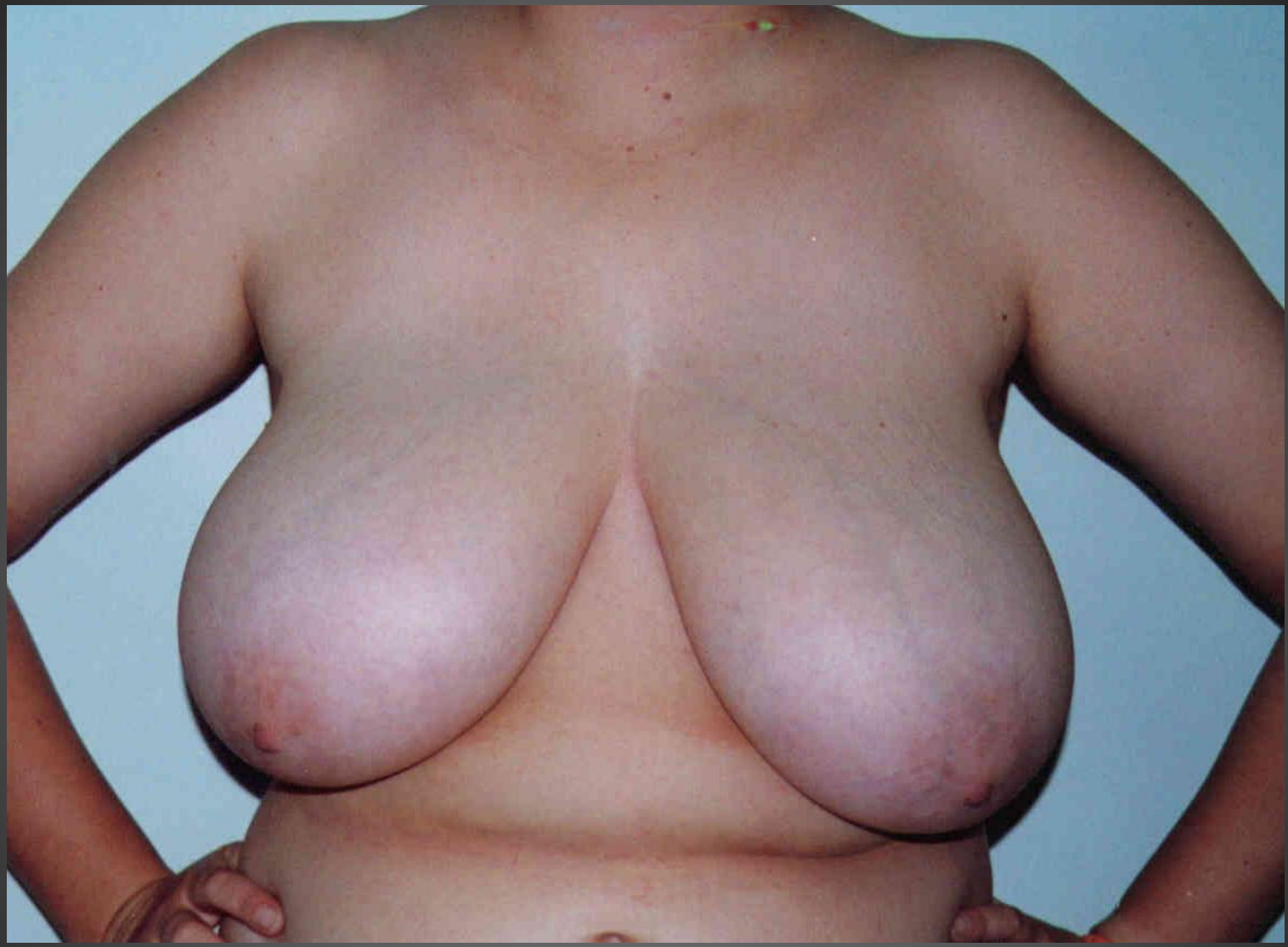
Shelve the pedicle laterally for nerve preservation

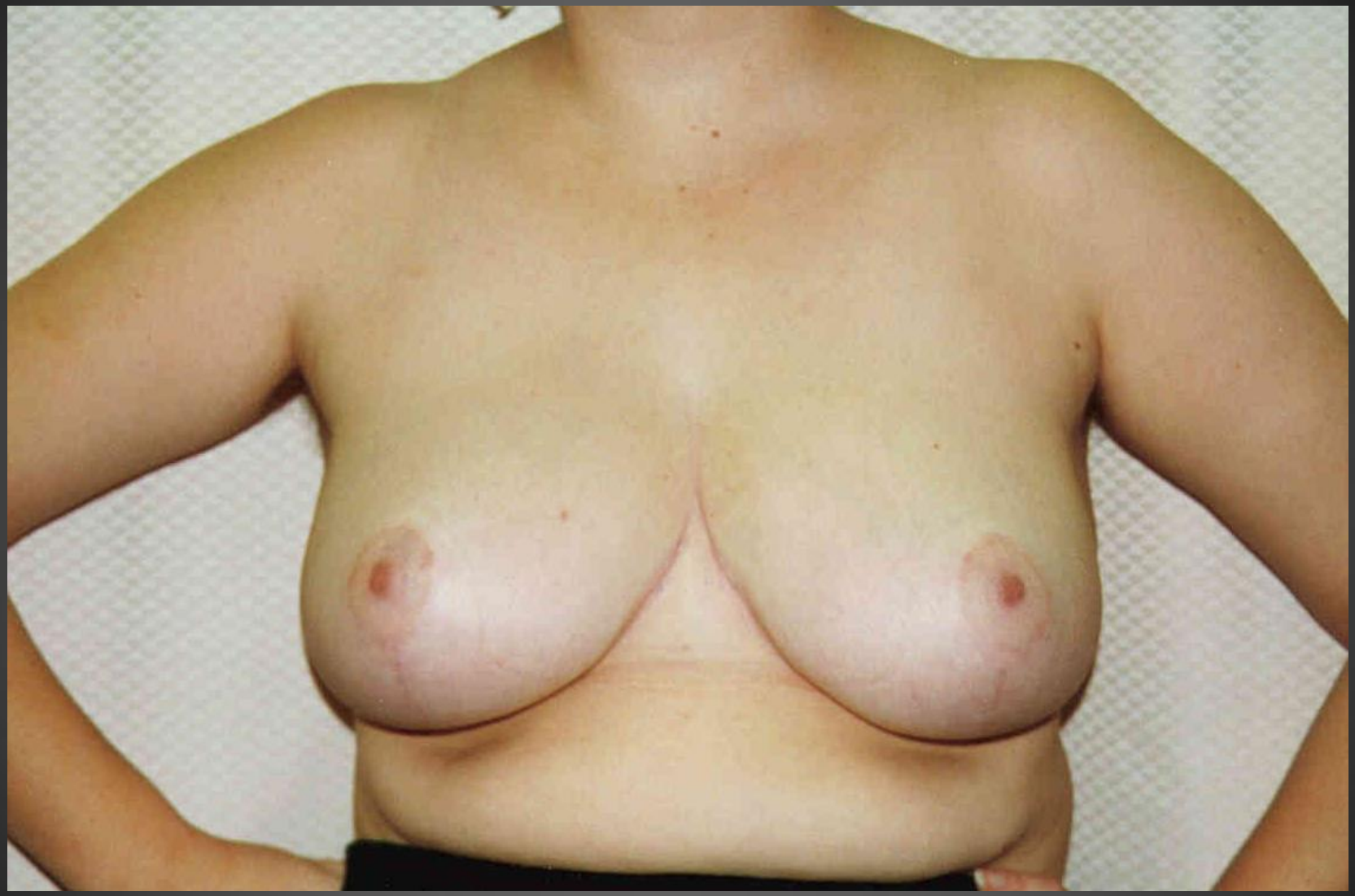
Do not undermine medially or centrally

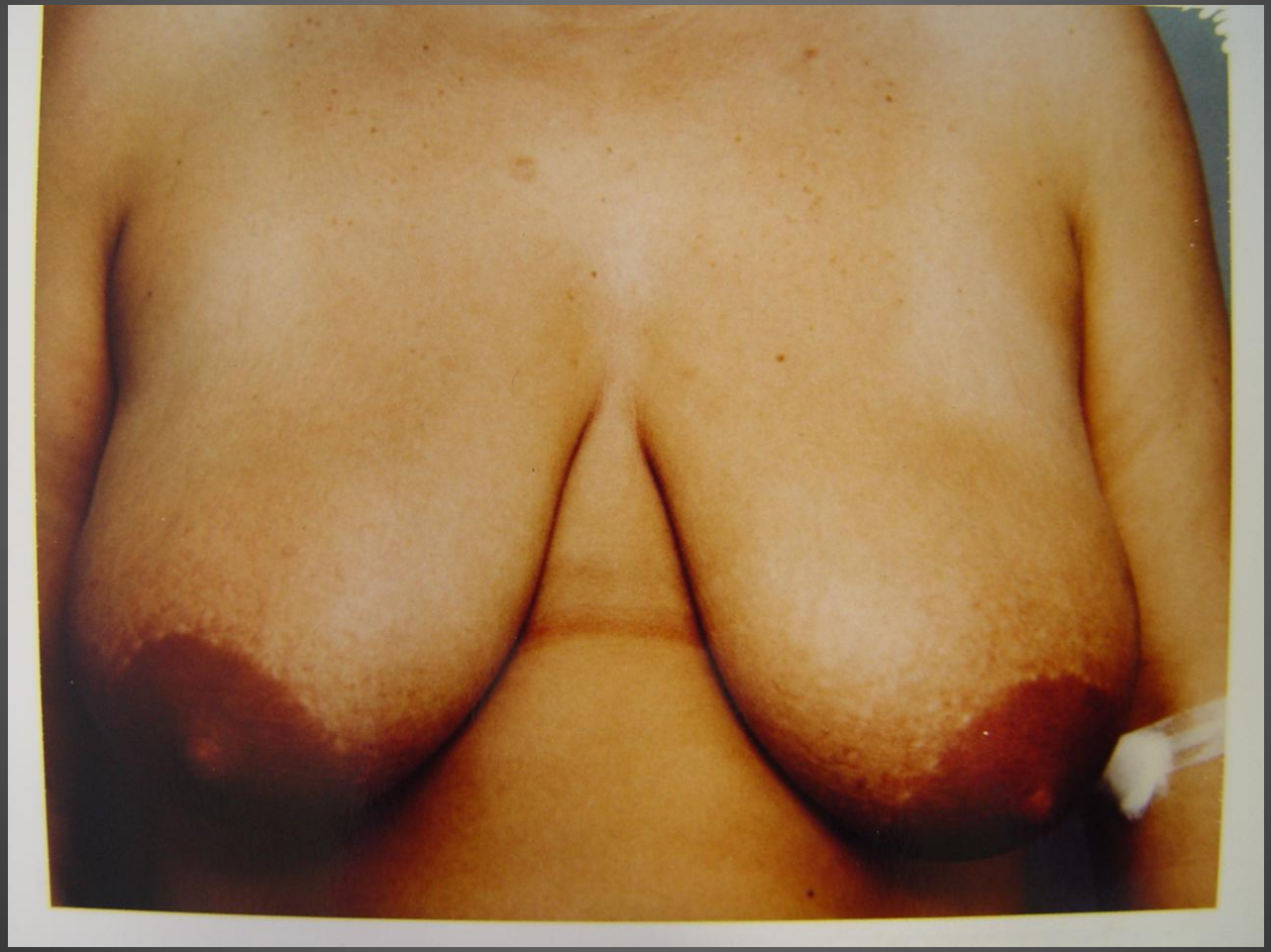


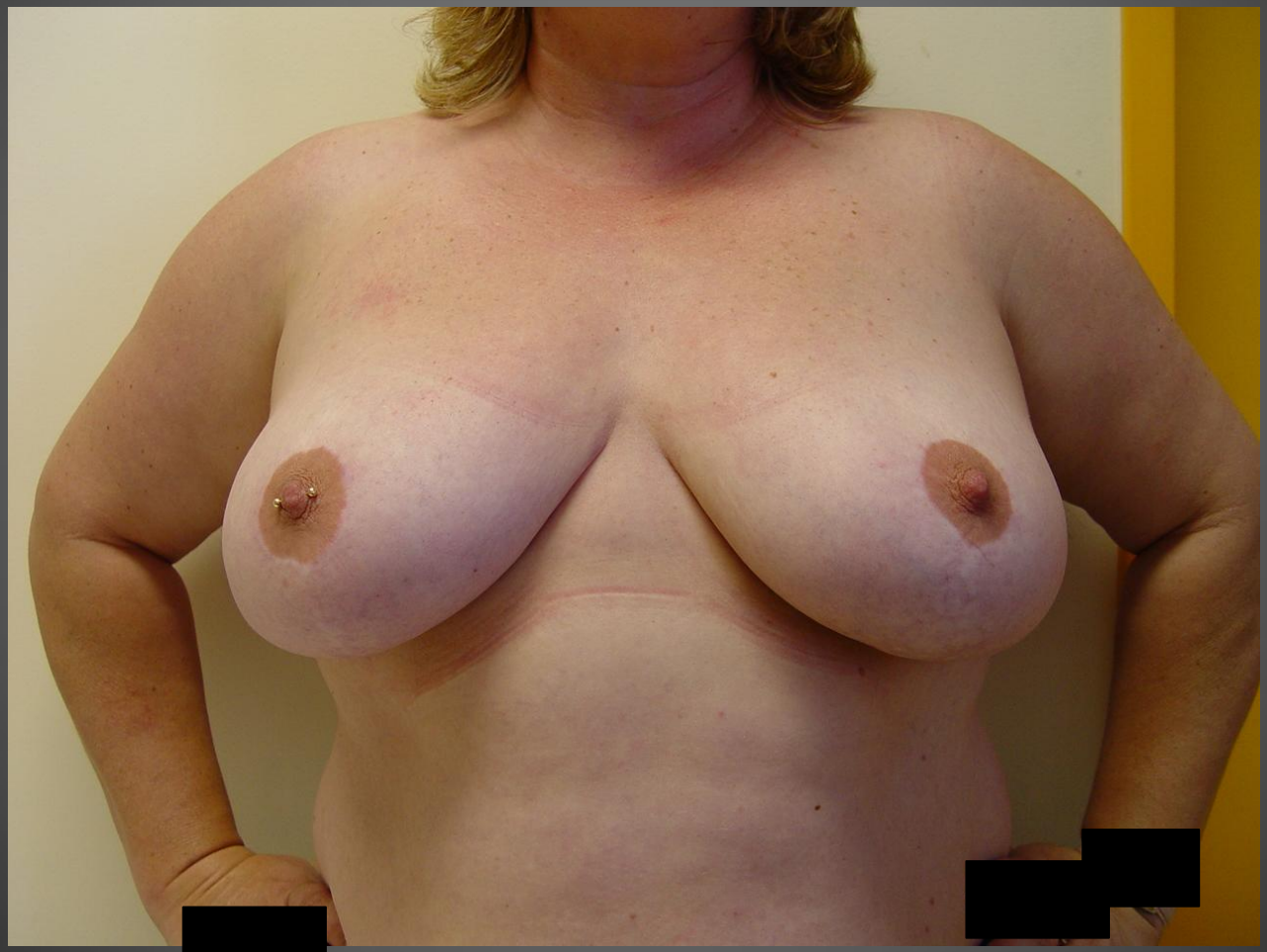
Leave no lateral dog ears, feed them in to the centre

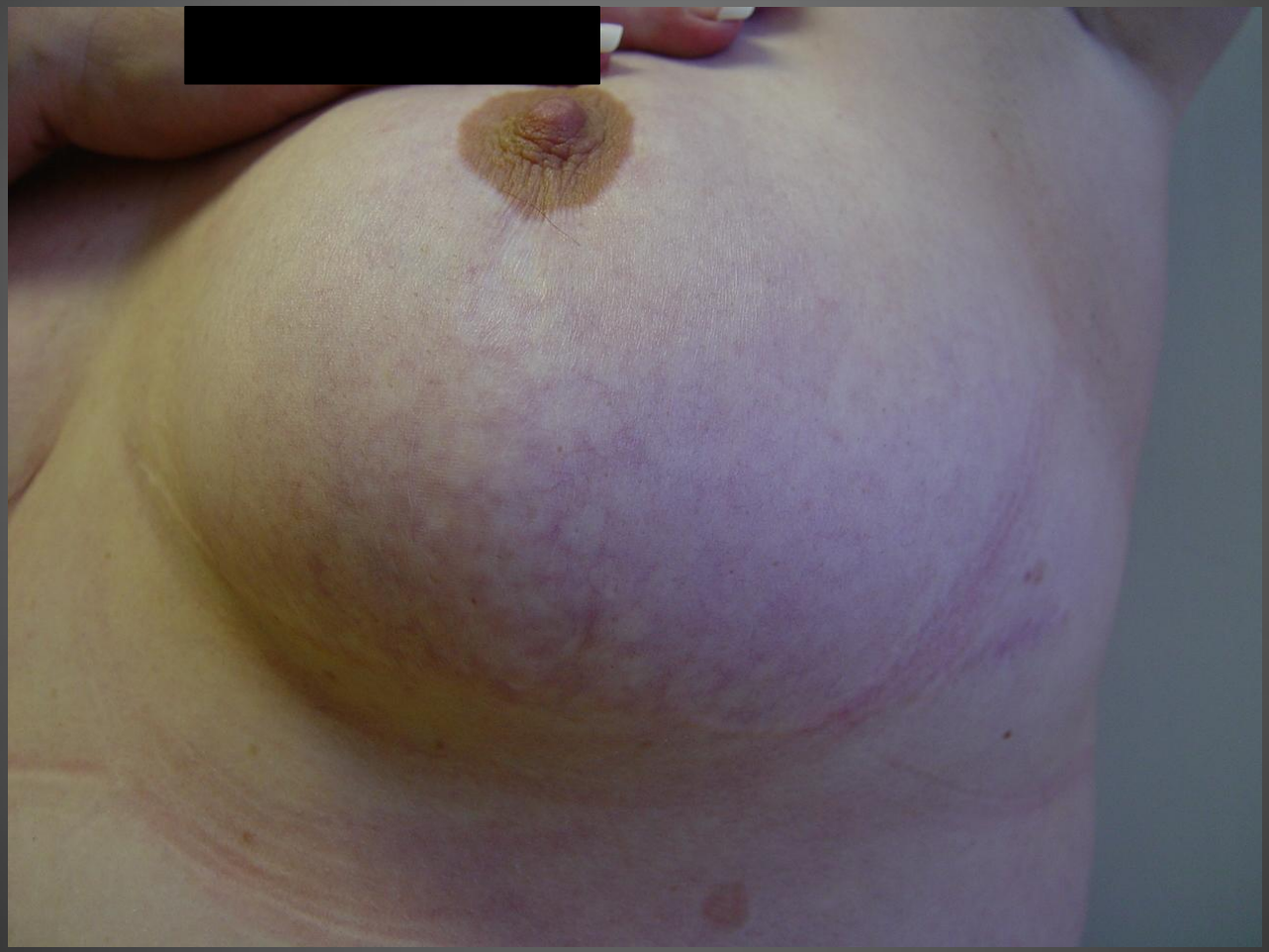


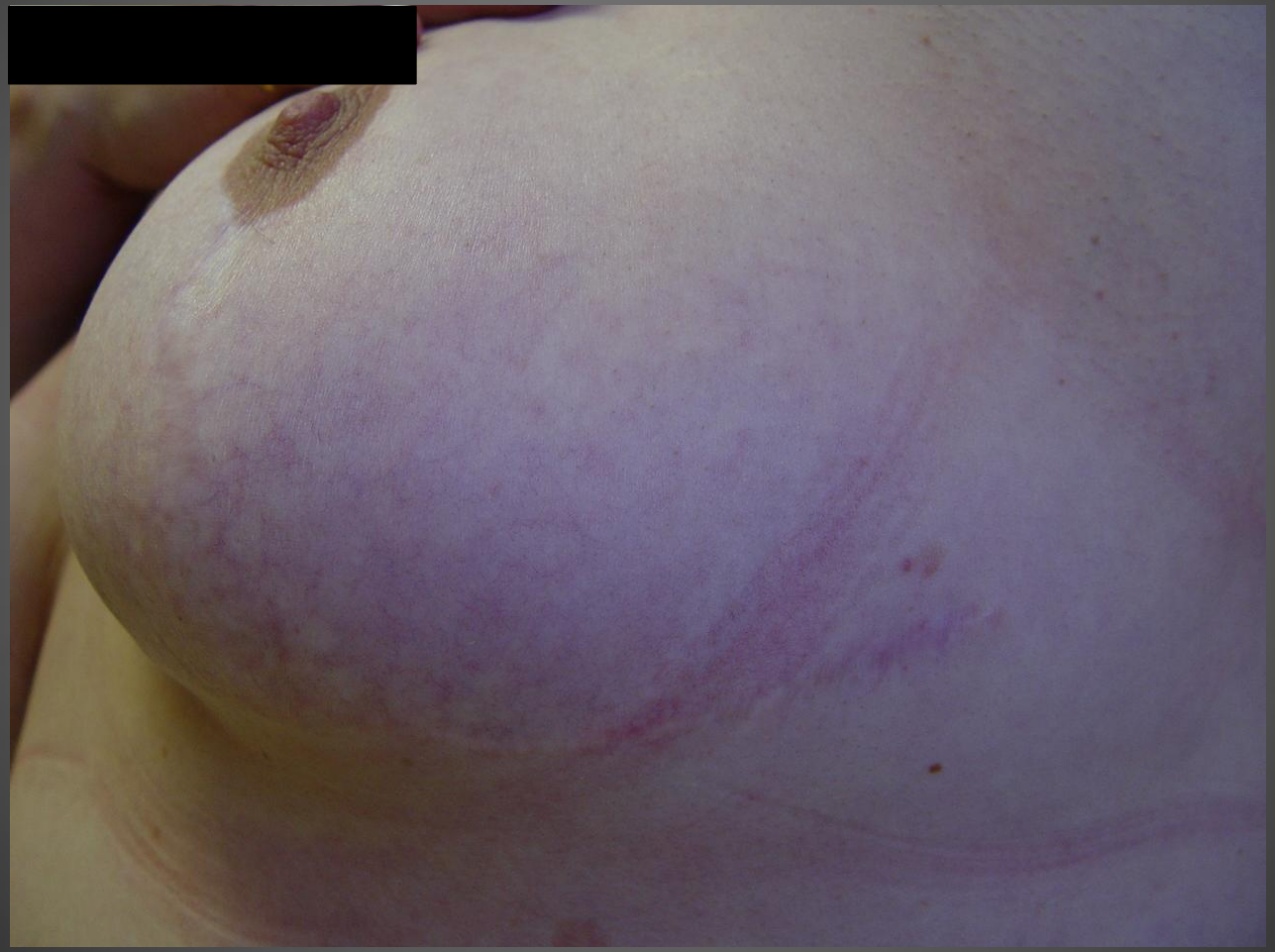








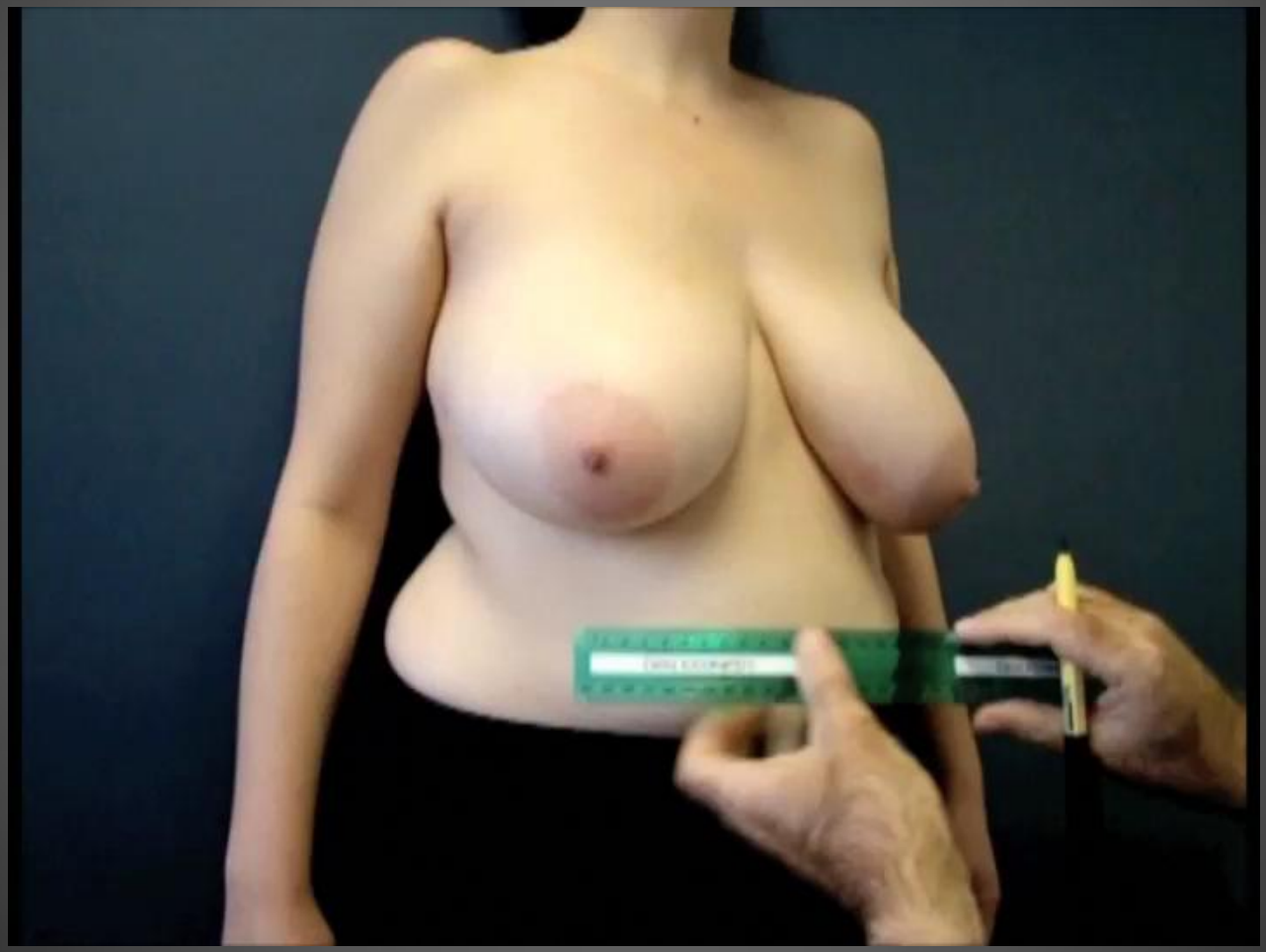


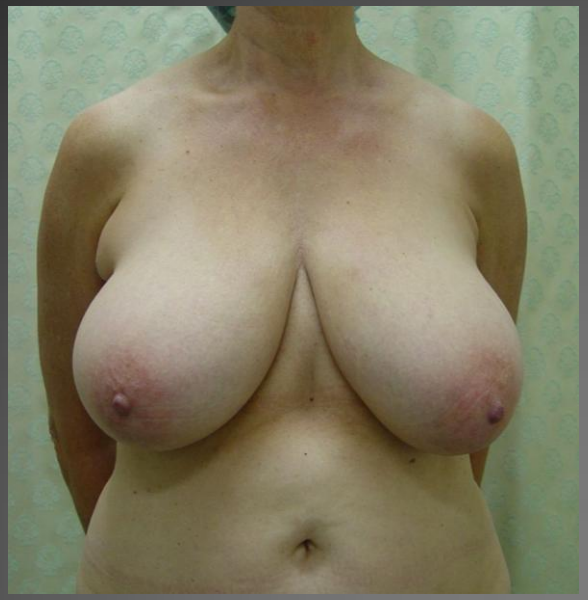


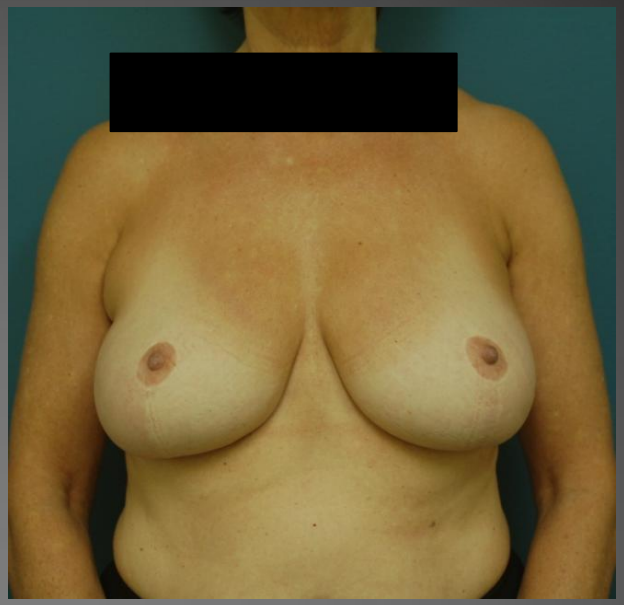
# Reduction

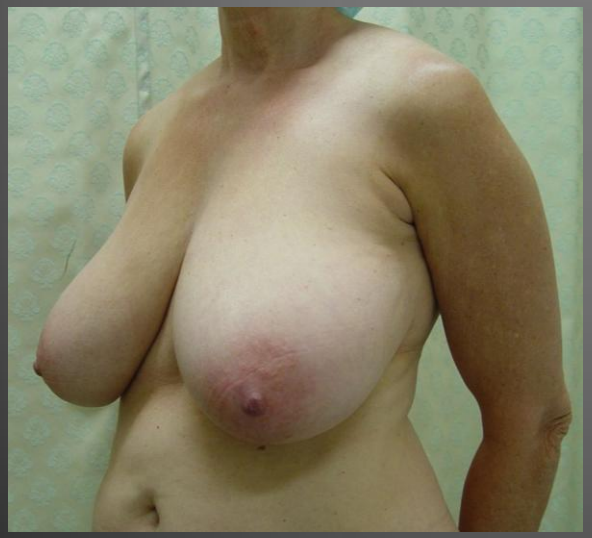
- Don’t put the nipple too high
- Don’t make the breast too small (whatever they say)
- Match the breast volume to the body habitus
- Don’t promise a particular cup size.

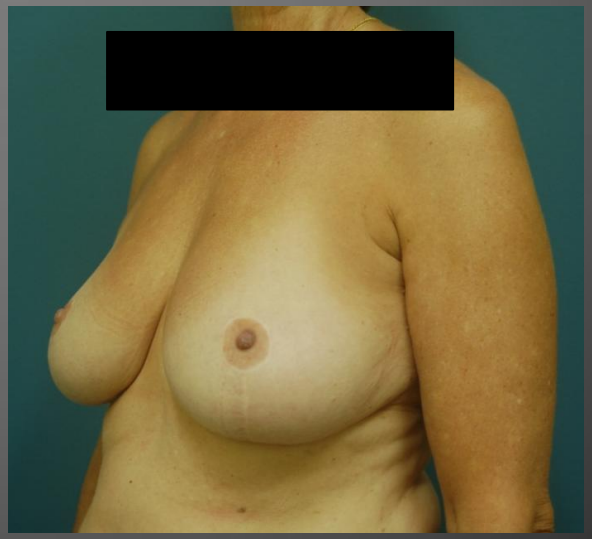
# Wise Pattern Markings











58yrs R) Breast = 443g L) Breast = 502g

# “Mastoplexy”

- “Will my nibbles be moved?”

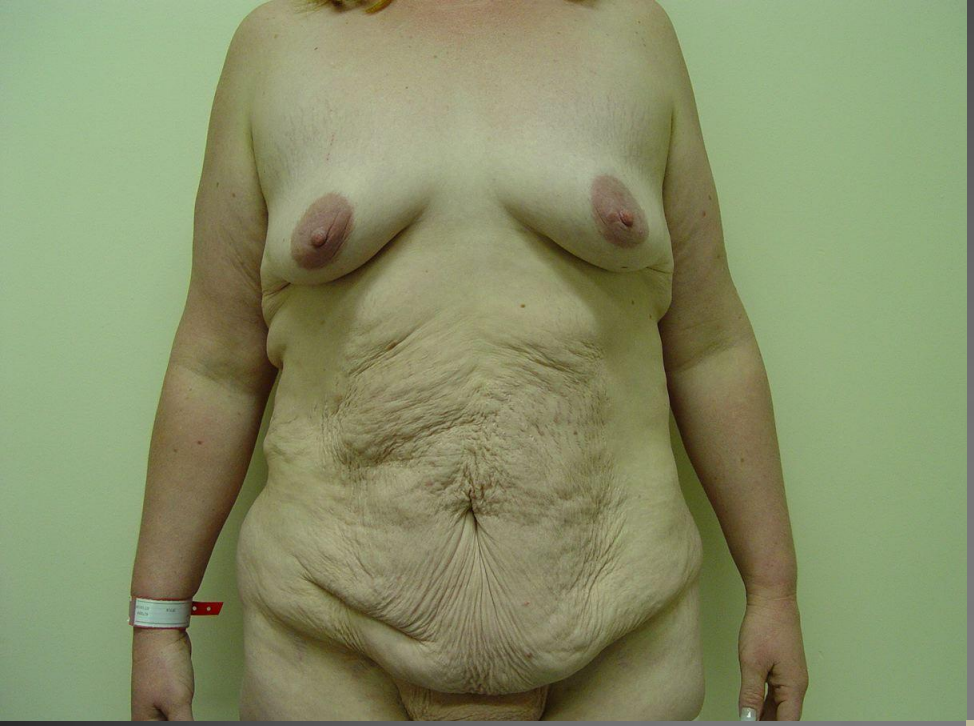
# Mastopexy

- When a mastopexy is desired because of MWL you have to consider the factors that led to the weight gain.

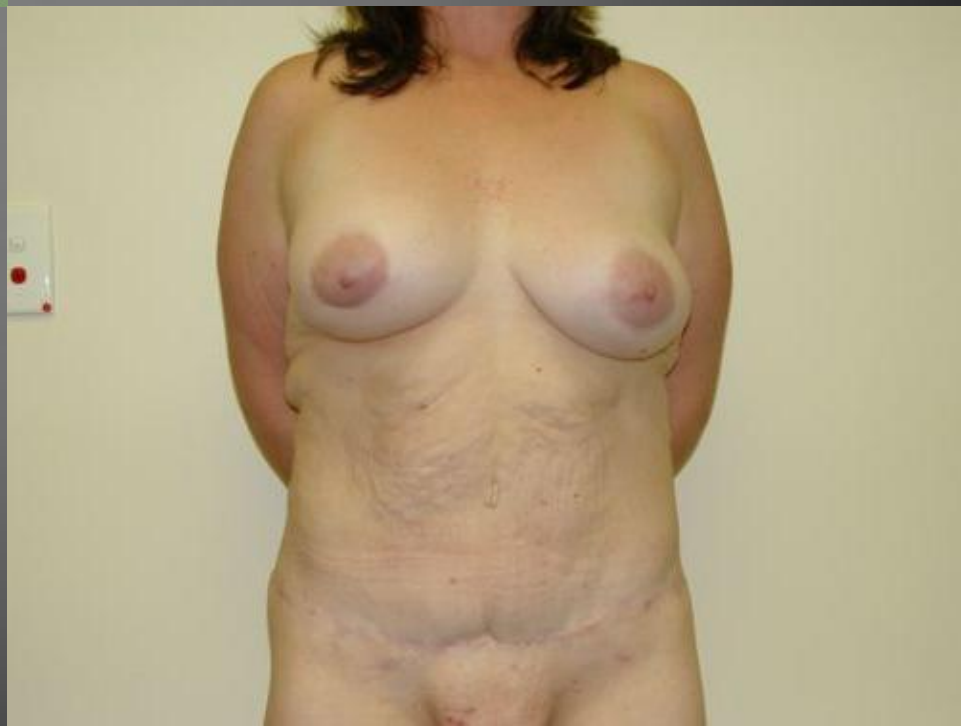
- Personality traits, relationship difficulties are often a feature.
- Weight gain is a risk

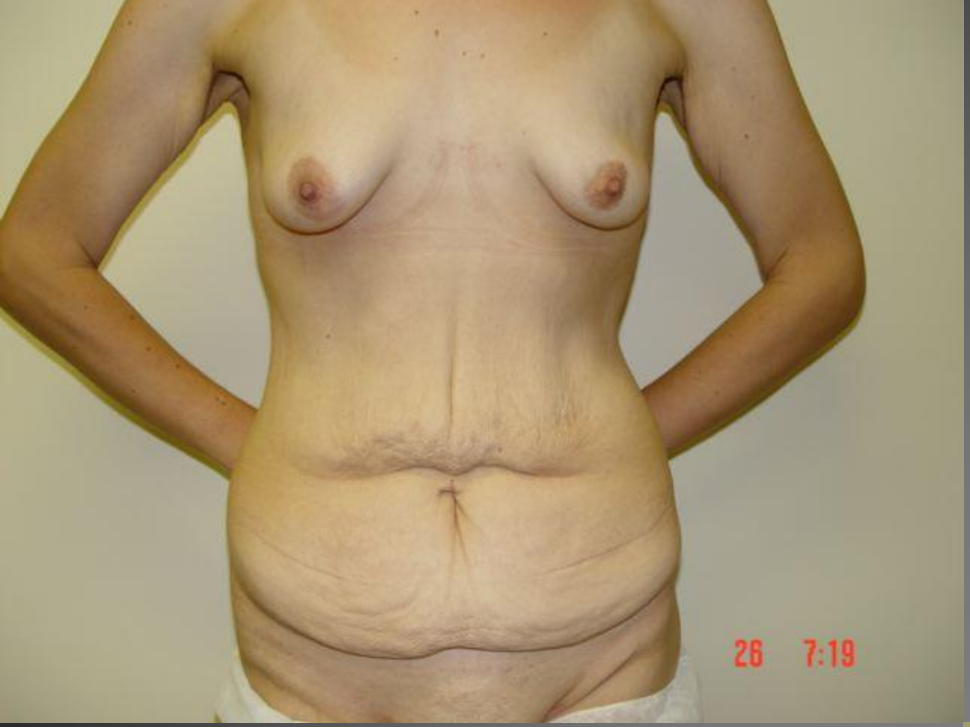
# Mastopexy

- What do they want? (Upper pole fill?)
- What can you achieve?
- Can they be happy with the limitations
- Do you want to trust your reputation to them?



# Implant



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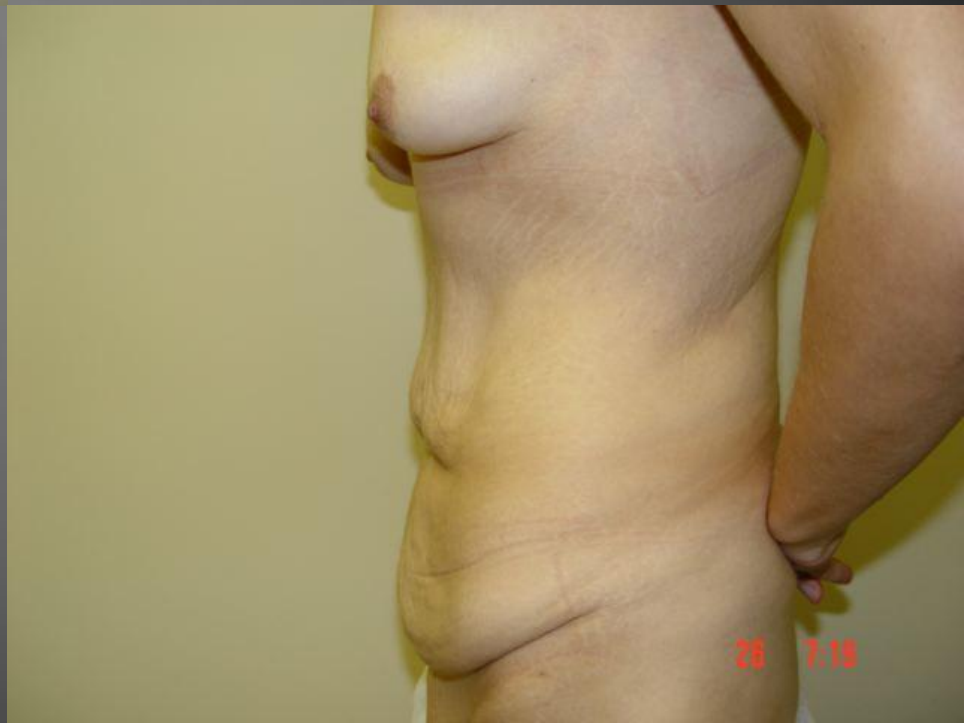
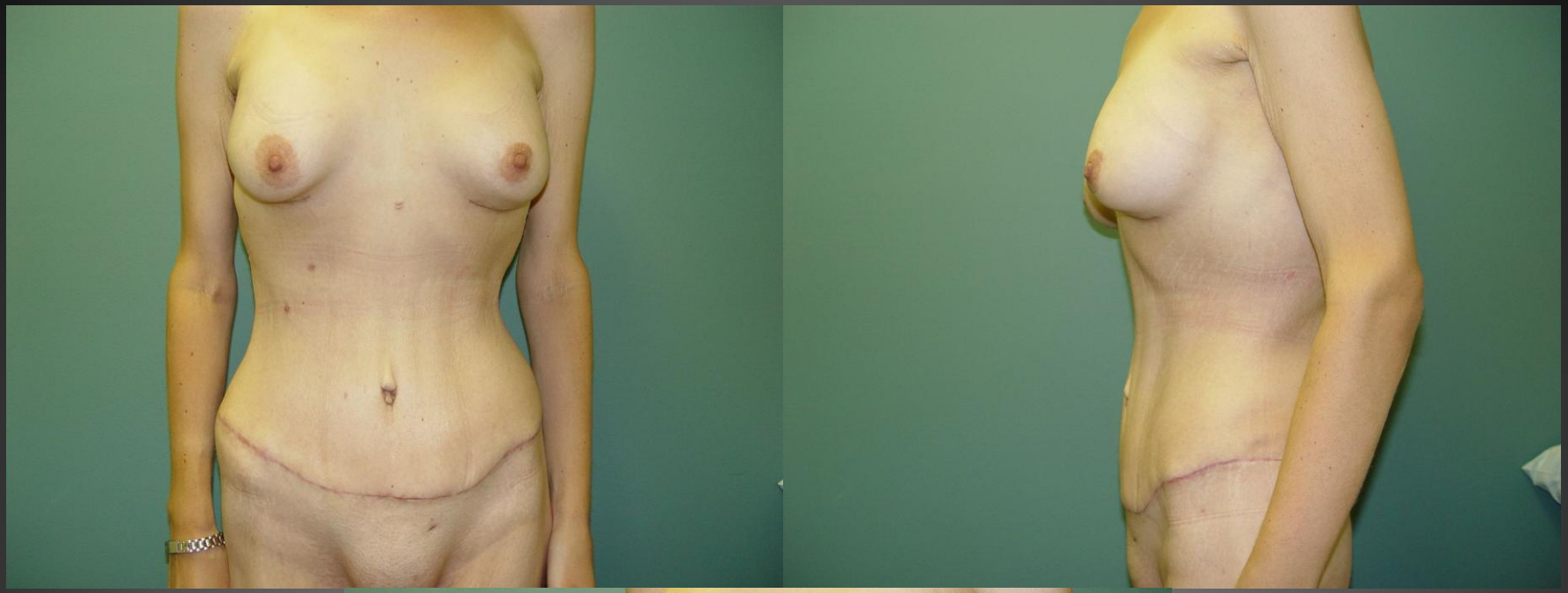
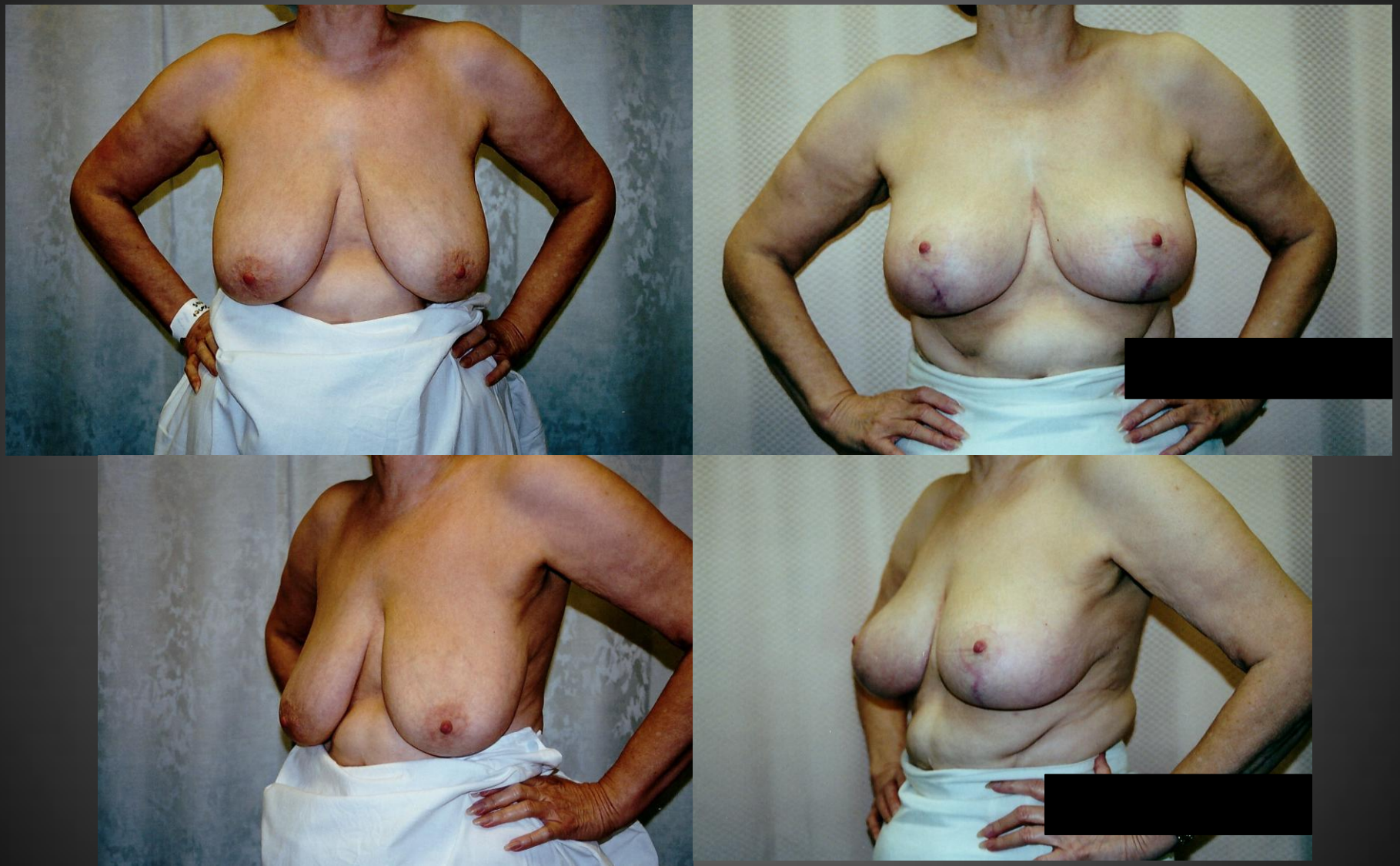


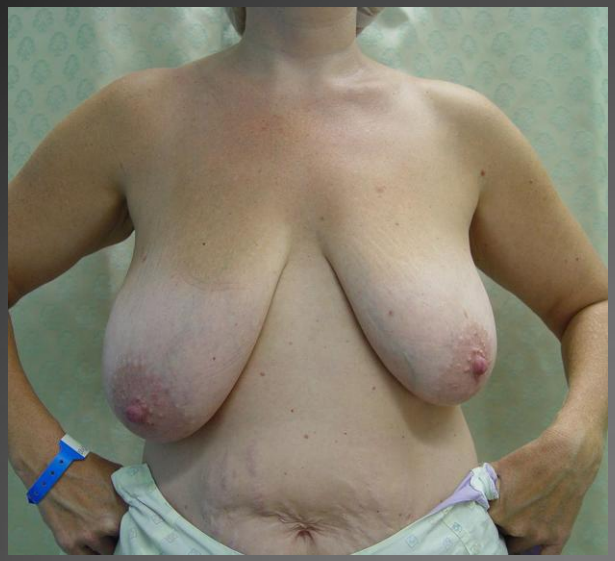


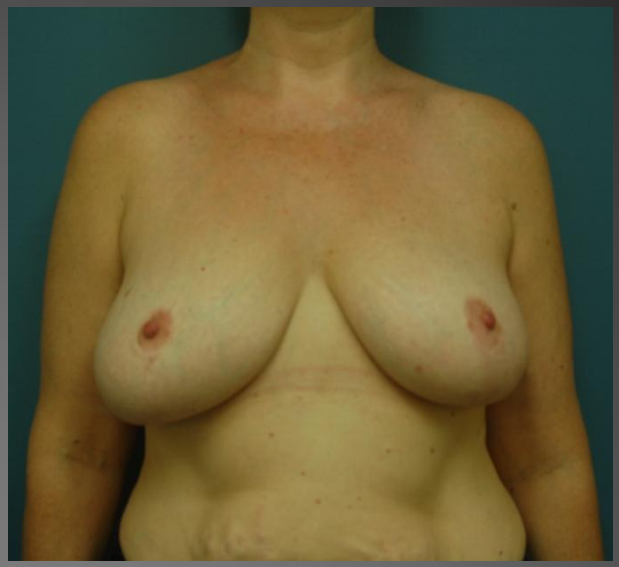
# Lift only

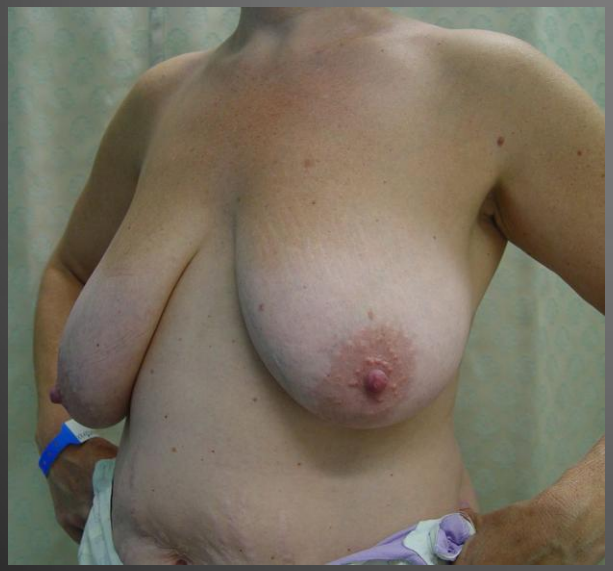


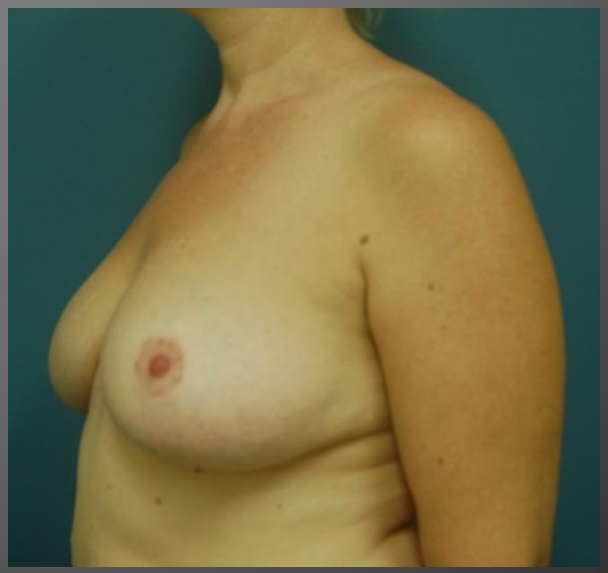
# Small reduction.

- Often more effective than a lift only

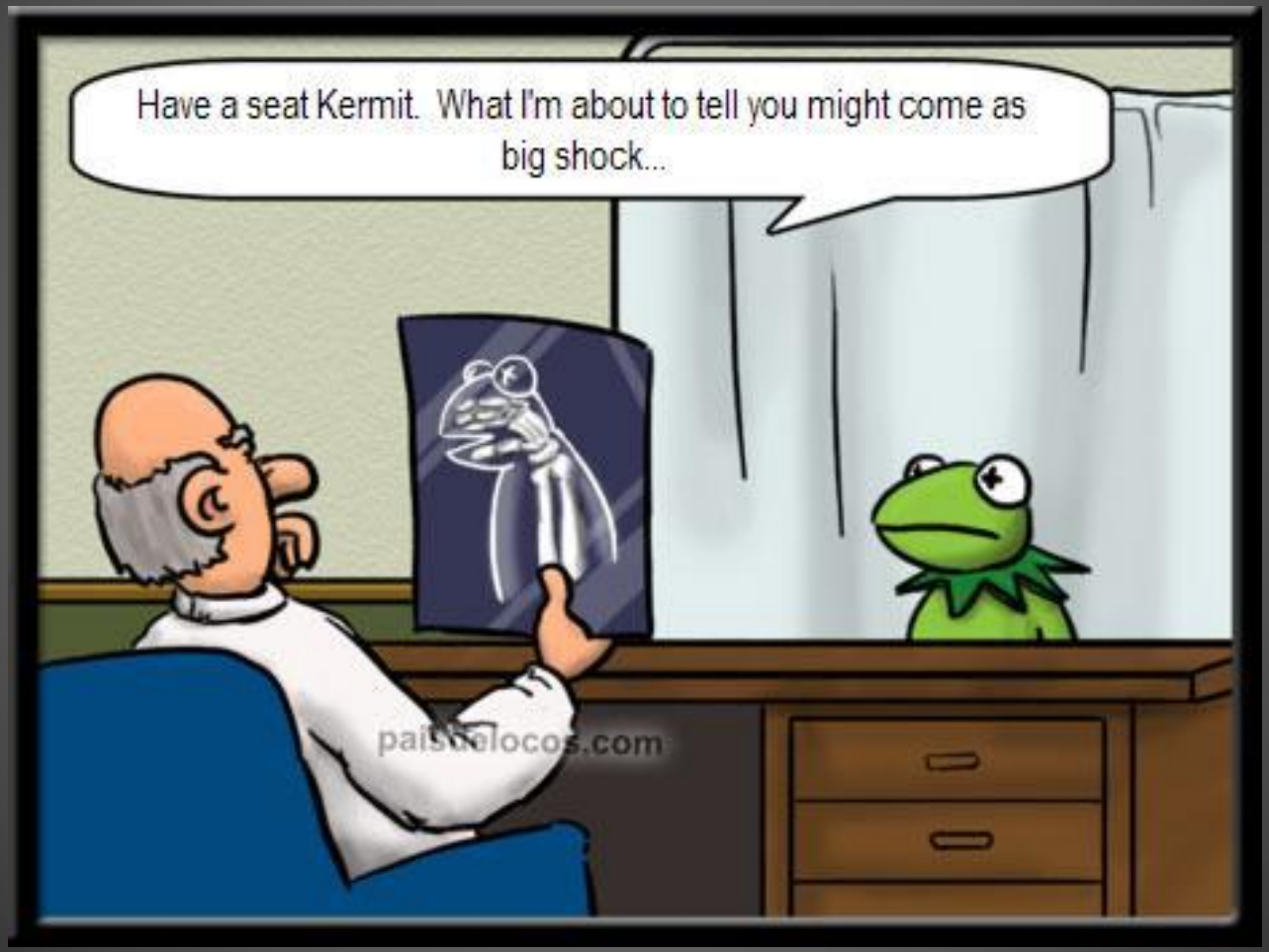








**35 yrs R) Breast = 365g L) Breast = 216g**


Have a seat Kermit. What I'm about to tell you might come as big shock...
paisdelocos.com

# Lift and implant

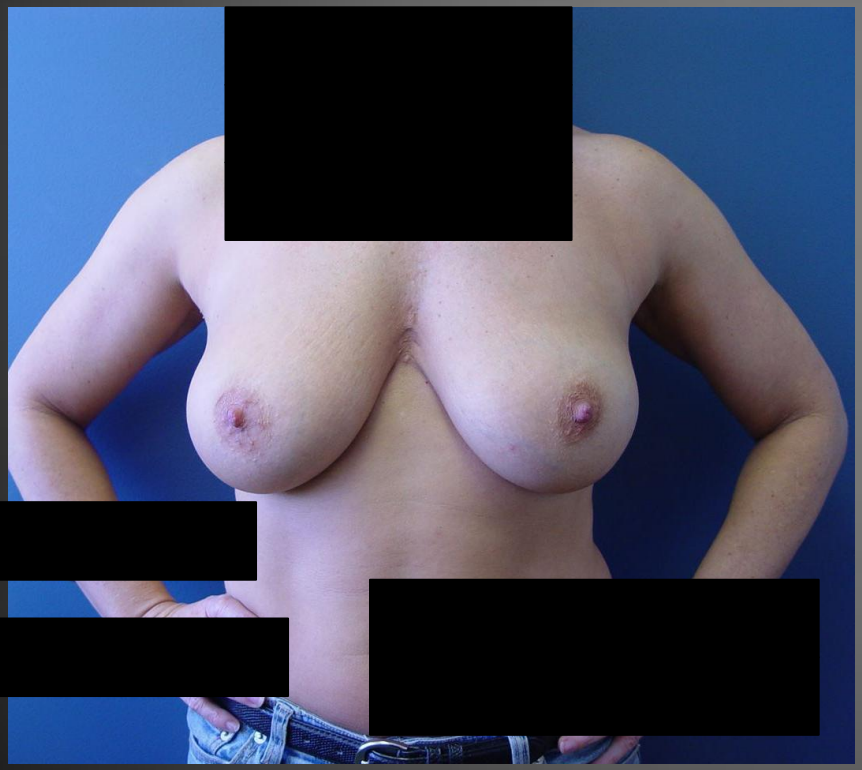
- Two stage
- One stage

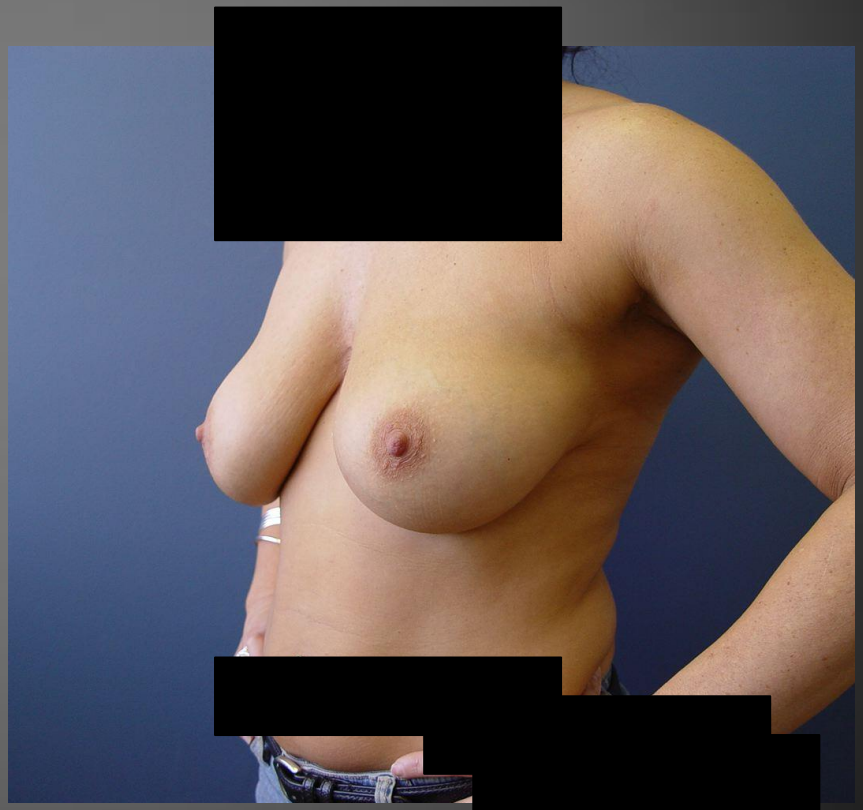
# Pre-Op

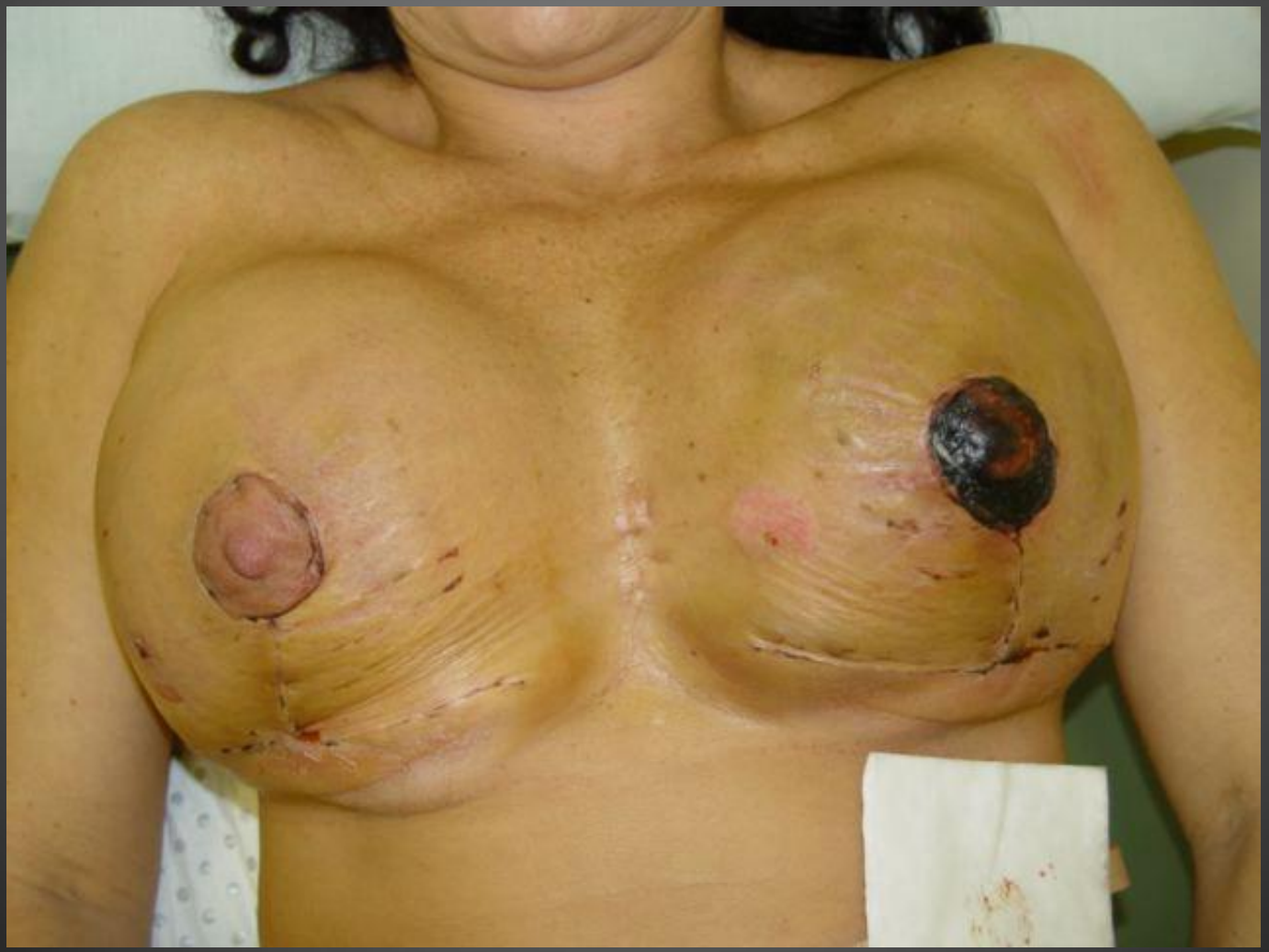
- Height: 160cm
- Weight: 60kg
- Bra size: 10CC

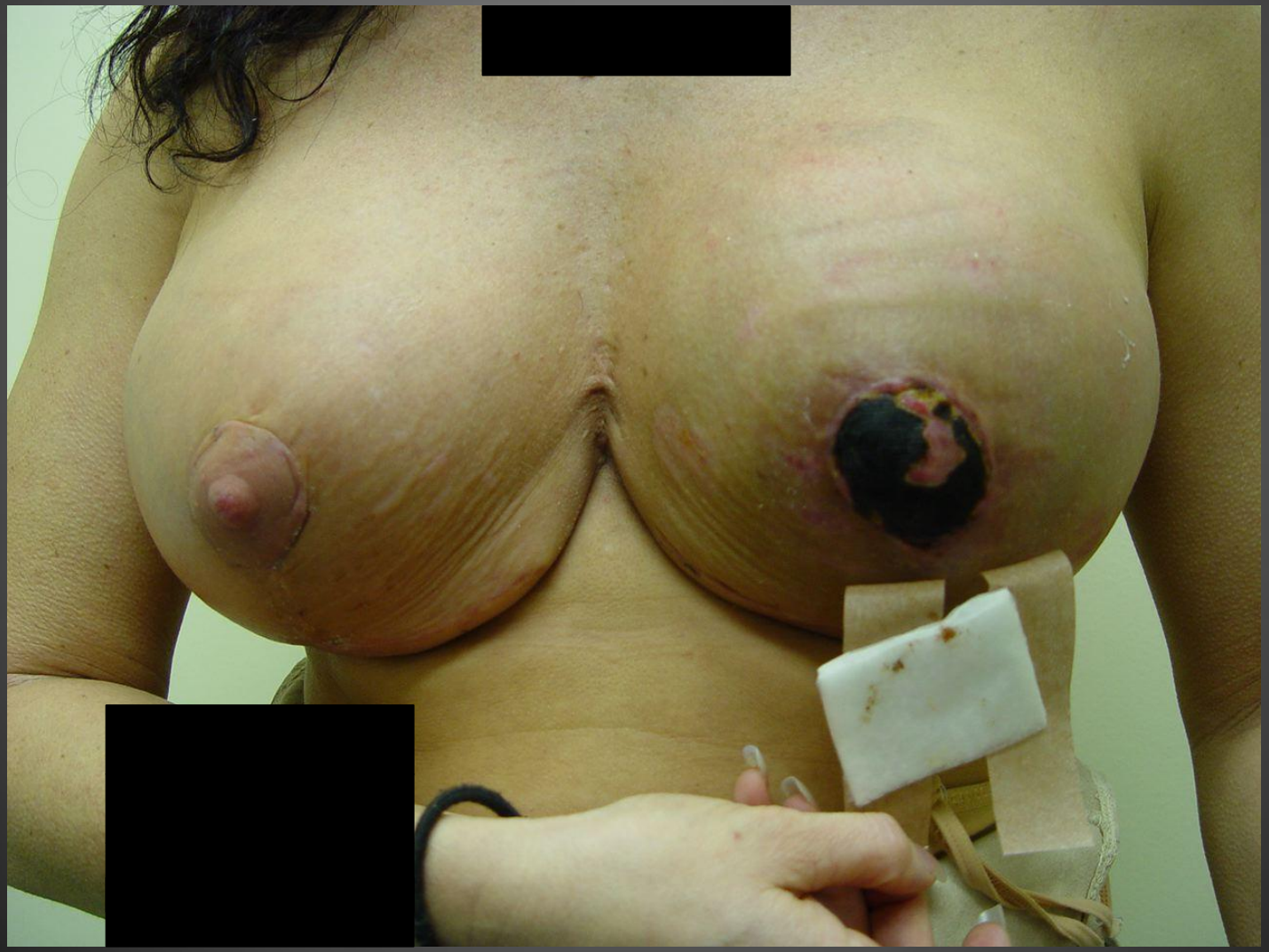

# Bilateral Breast Augmentation
# Post-Op

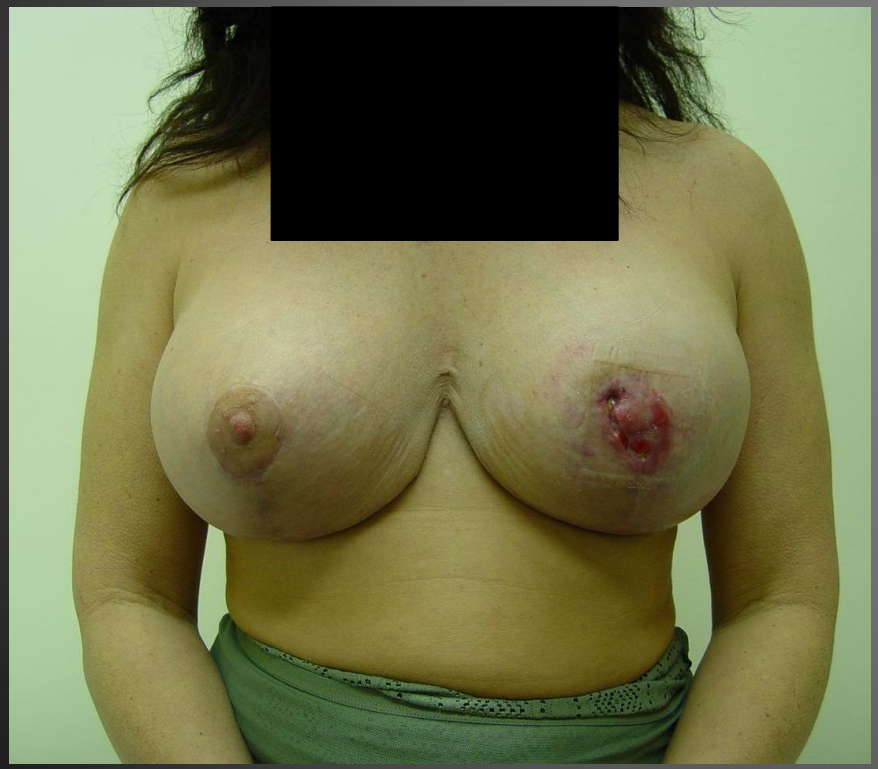
- Pre-pectoral pockets
- IM incision
- Implants: CMH 160g cohesive gel textured high projection

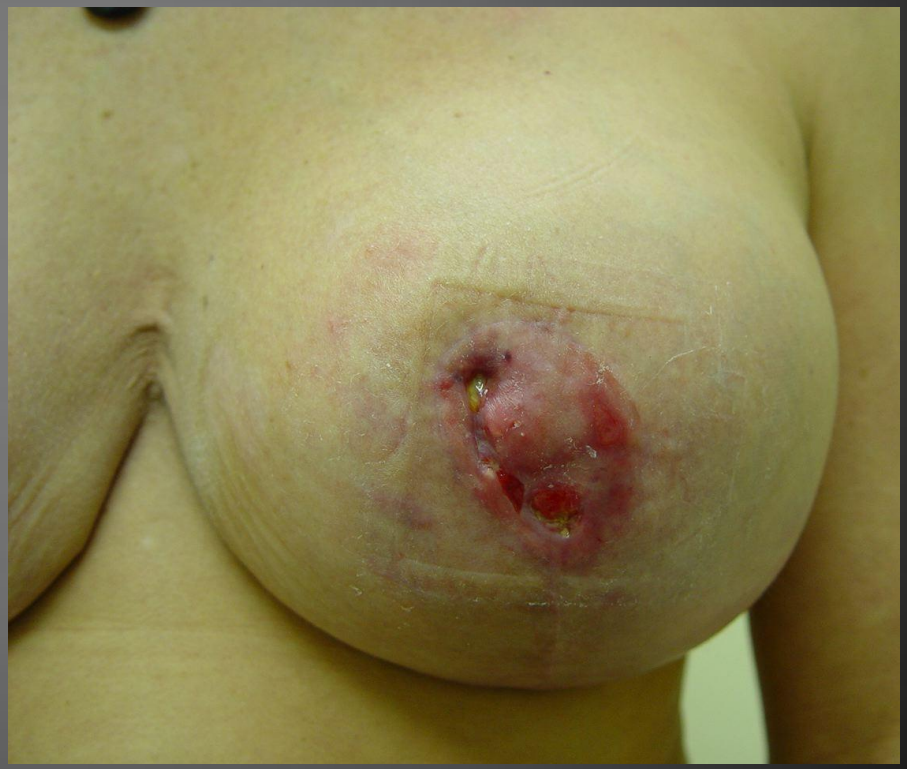






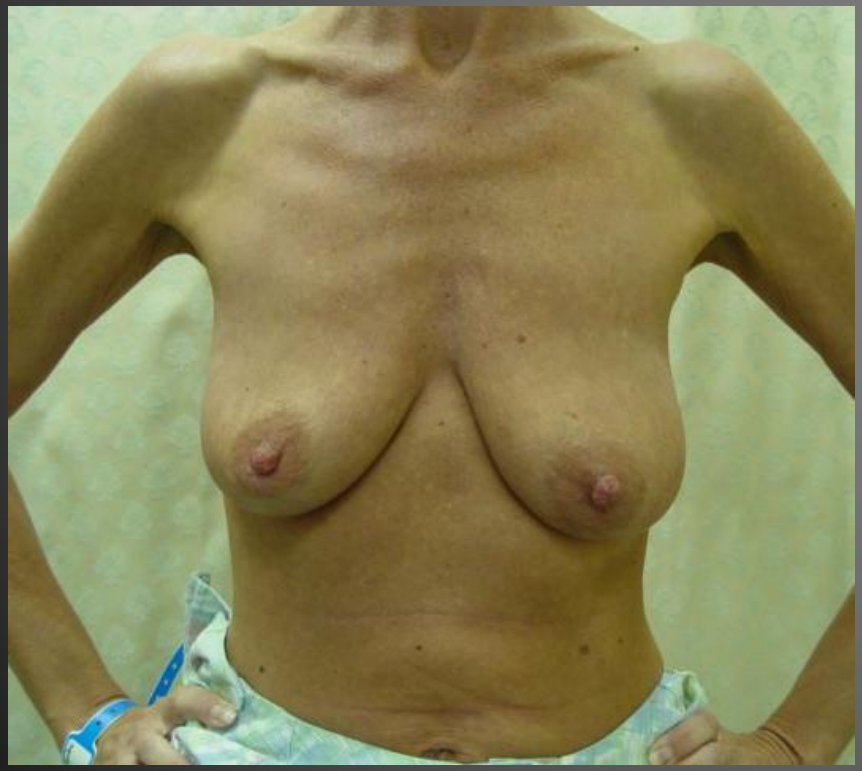


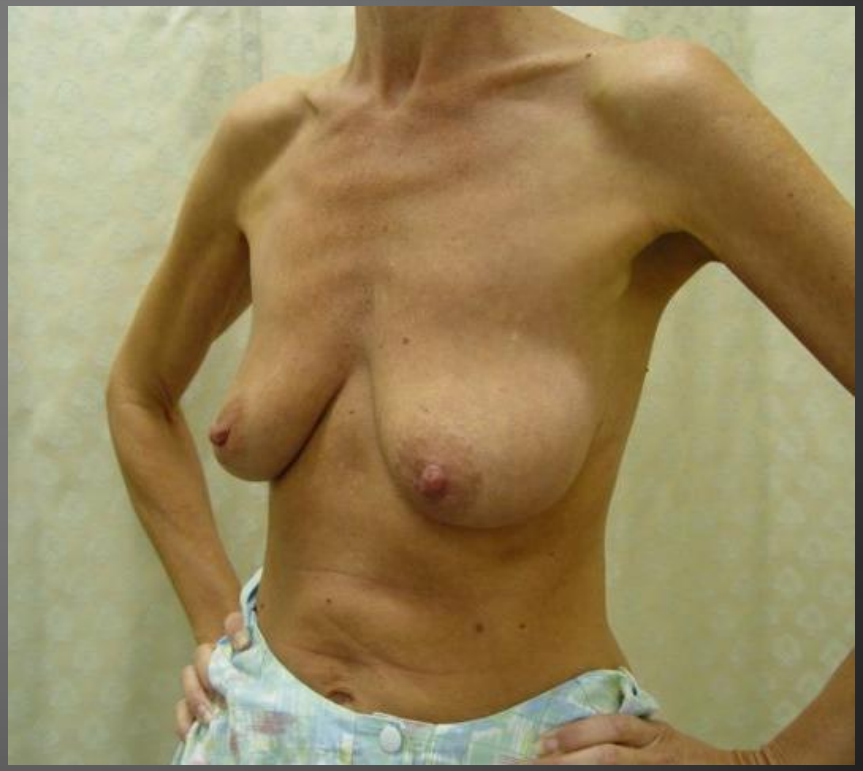




# Pre-Op

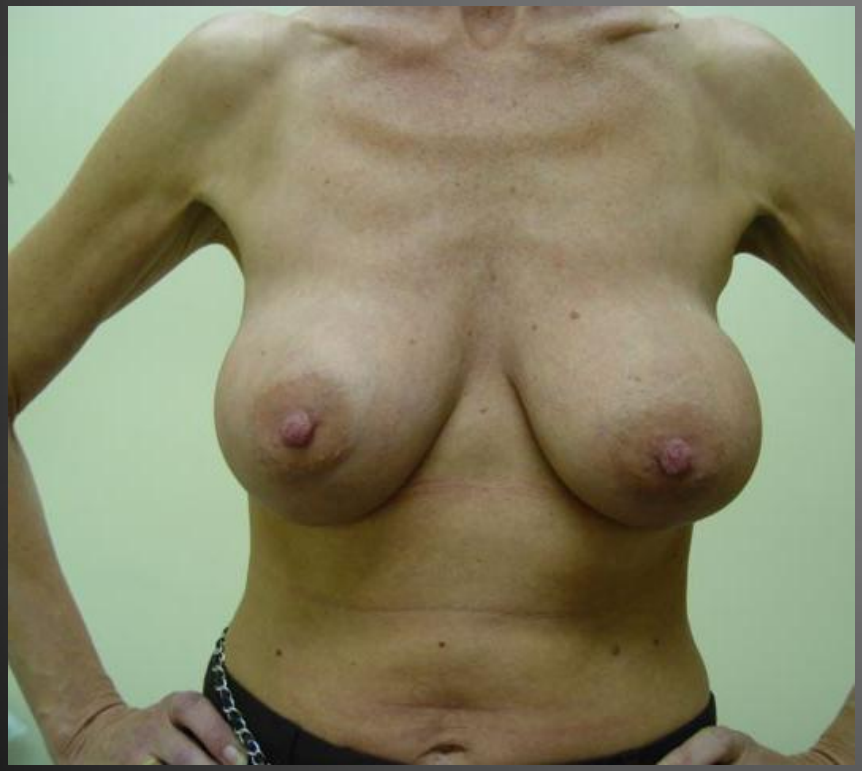
- Height: 175cm
- Weight: 61kg
- Bra size: B cup

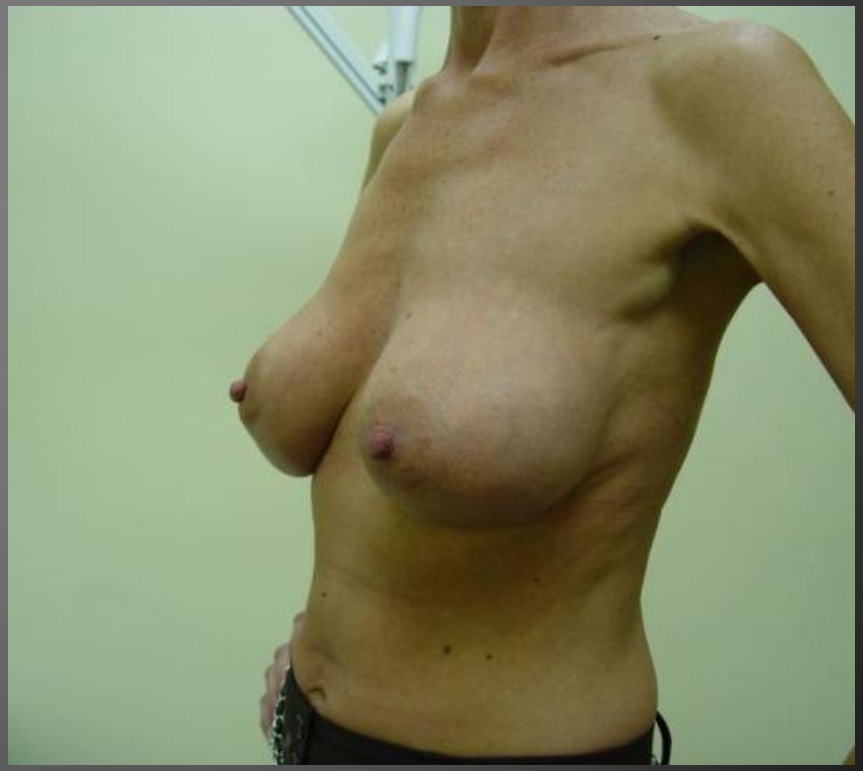




# Bilateral Breast Augmentation
# Post-Op

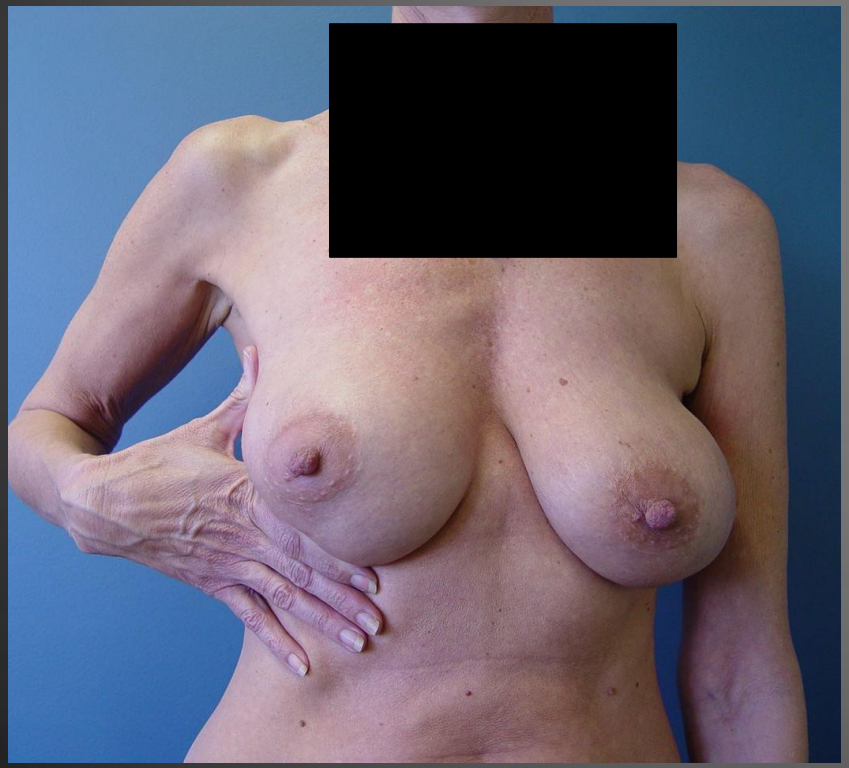
- Areolar incsion
- SM pocket
- Implants: Mcghan 255g cohesive gel teardrop implants

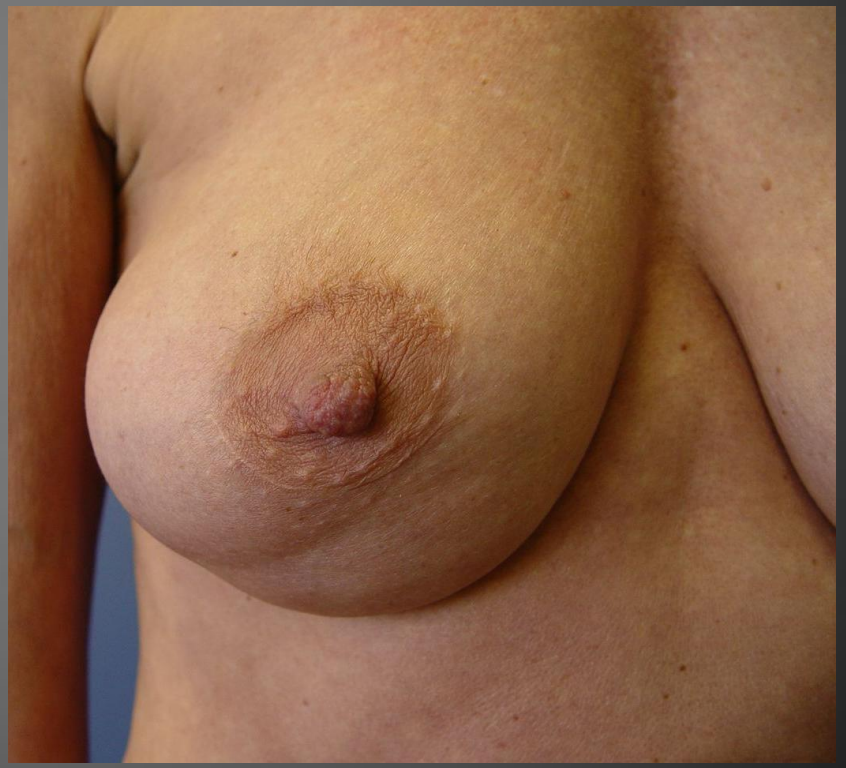


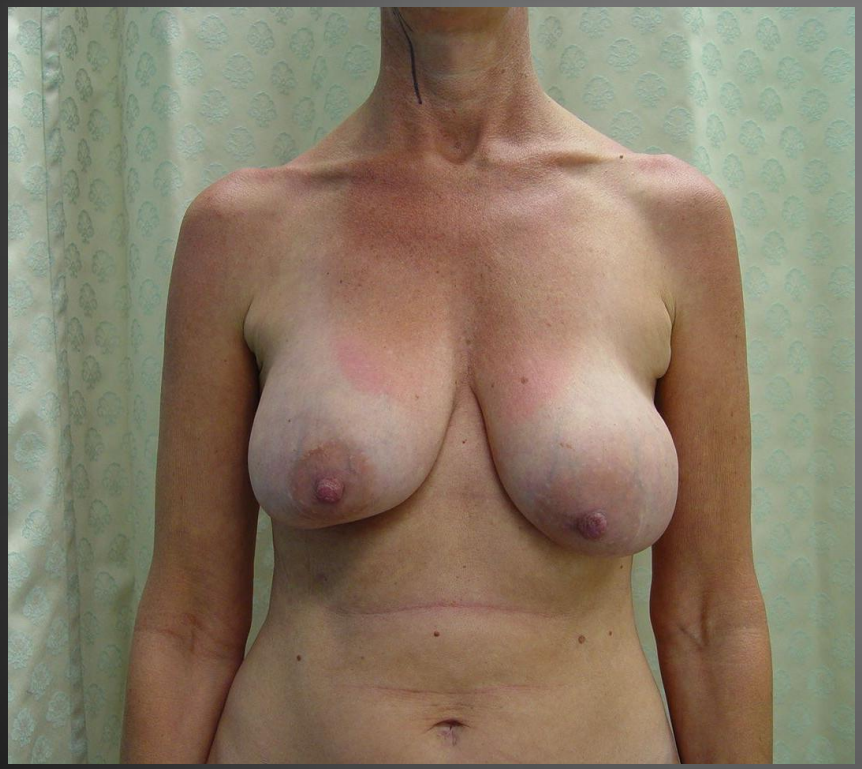


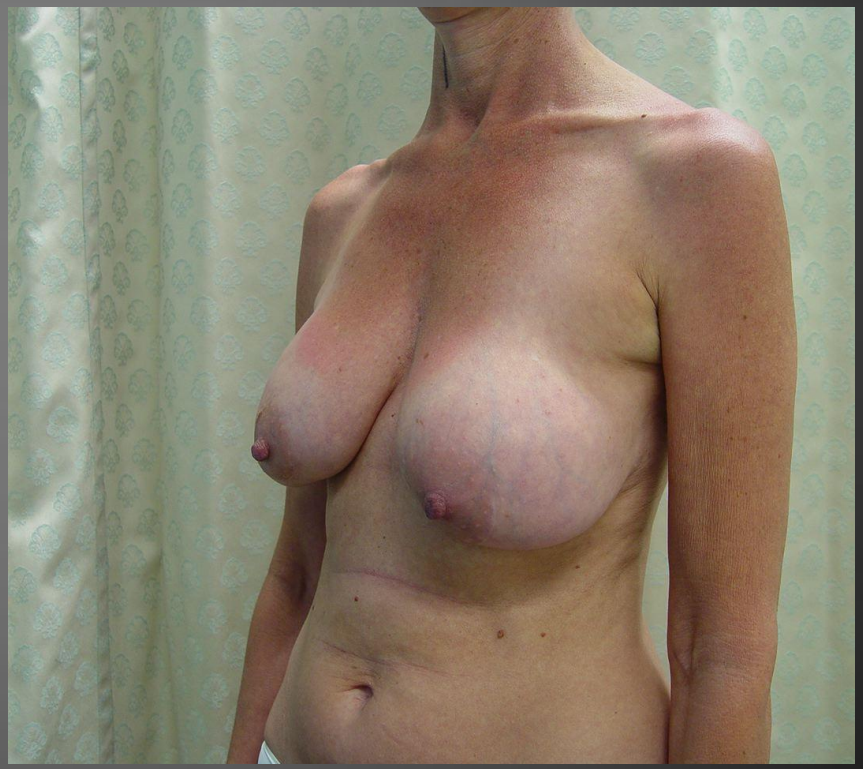
# Bilateral Breast Augmentation 1 year post-op

- Increased descent

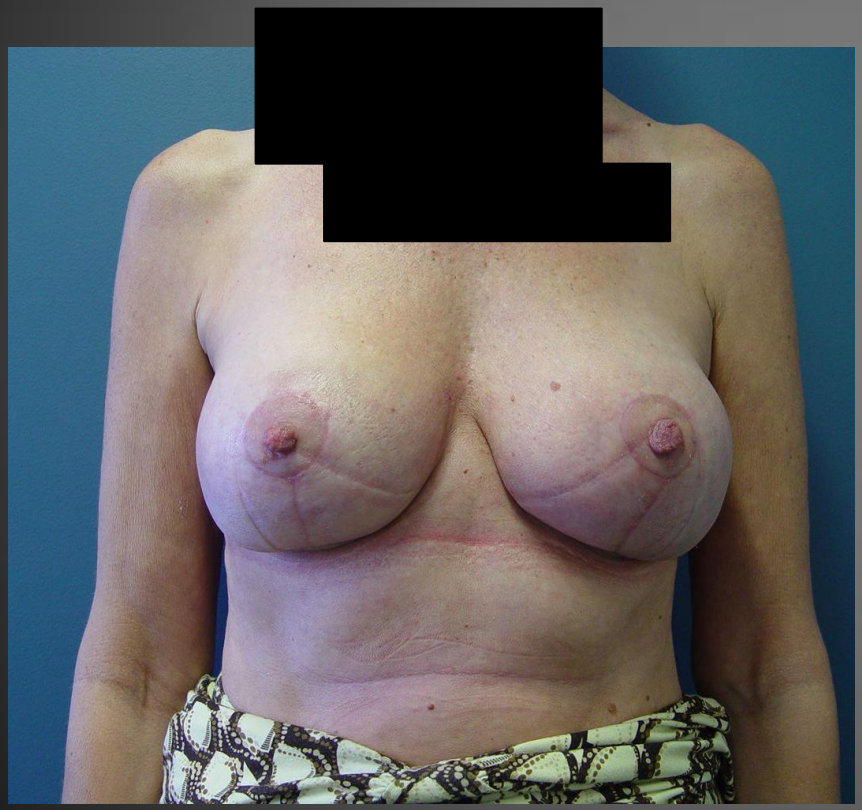


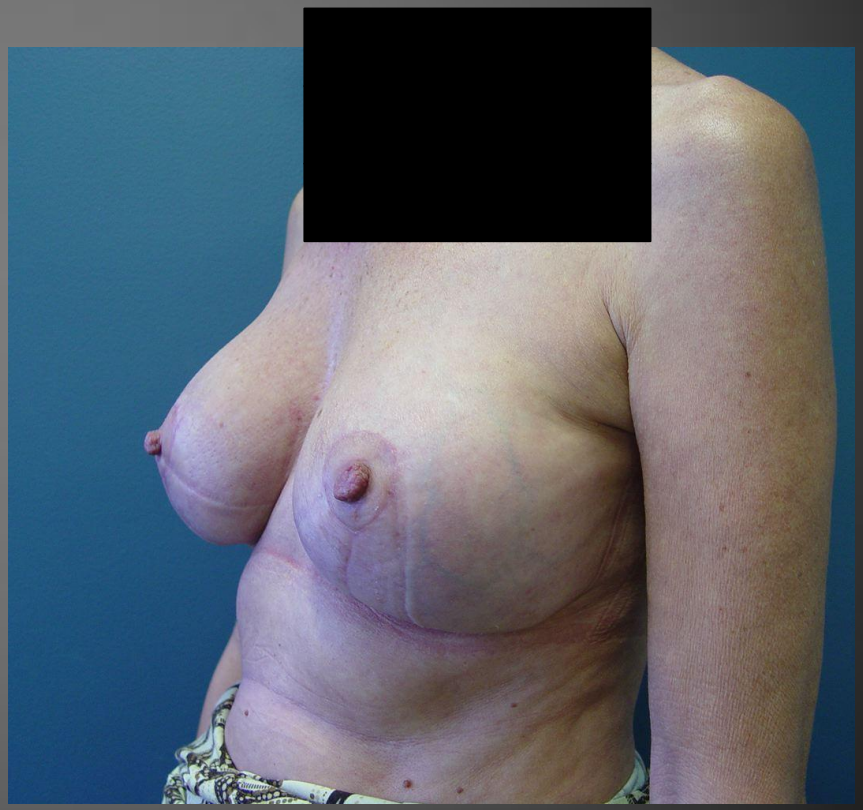




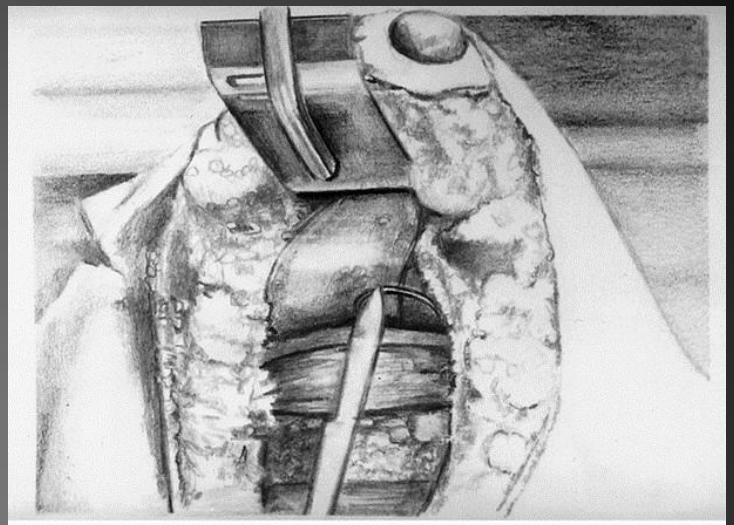


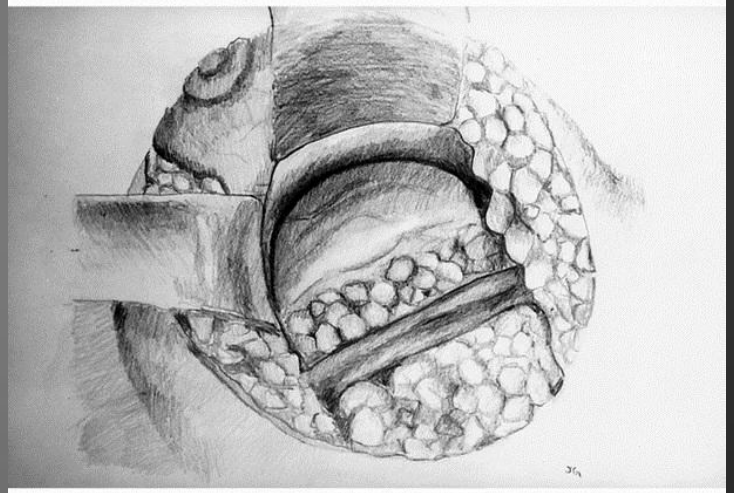
# R) Mastopexy L) Breast Reduction and repositioning of implants.
Post-Op

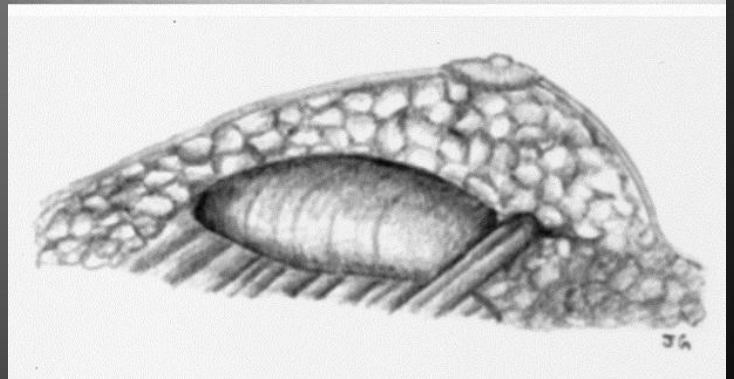


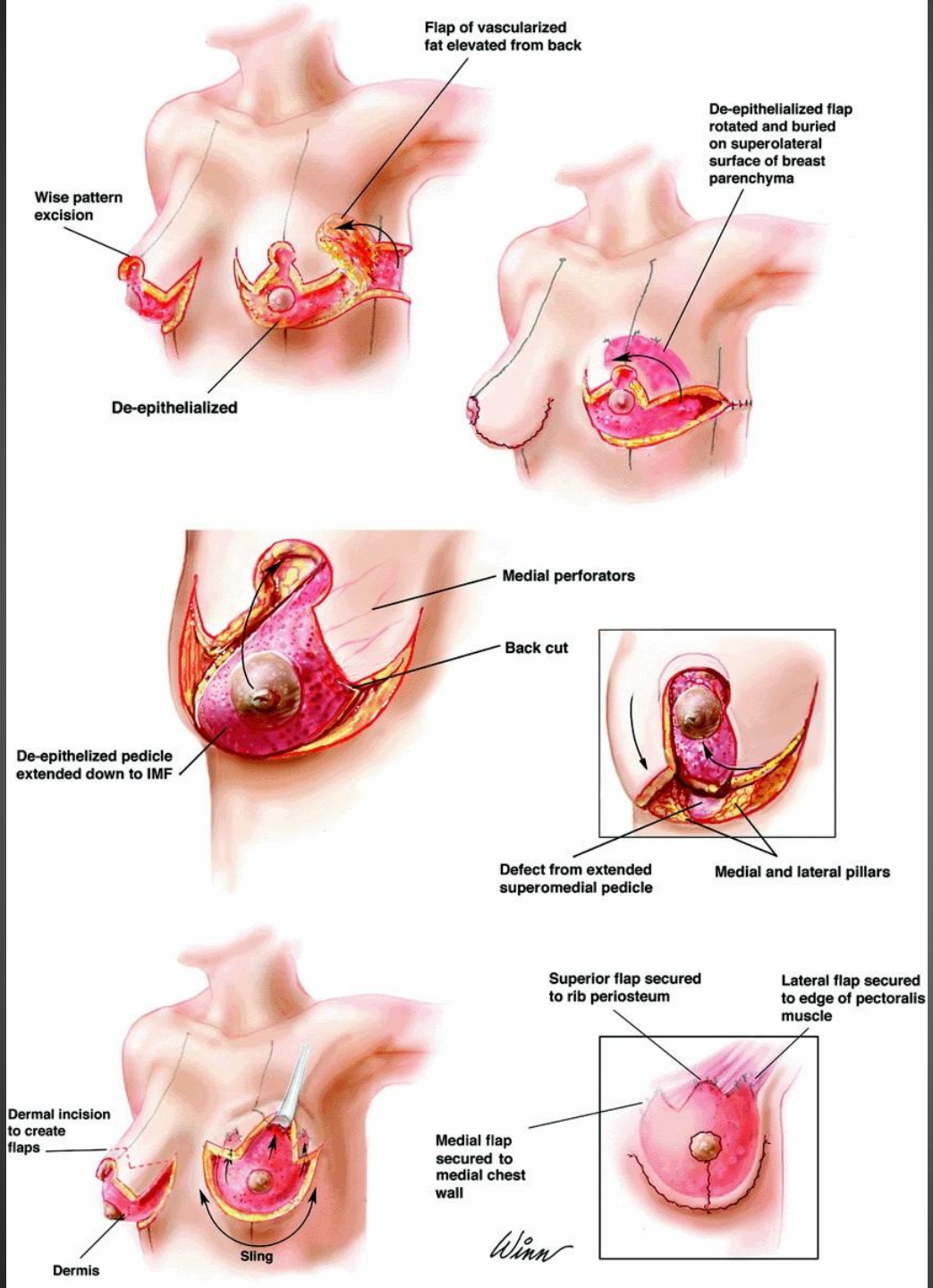


# GRAF 2002








Flap of vascularized fat elevated from back
Wise pattern excision
De-epithelialized
De-epithelialized flap rotated and buried on superolateral surface of breast parenchyma
Medial perforators
Back cut
De-epithelized pedicle extended down to IMF
Defect from extended superomedial pedicle
Medial and lateral pillars
Dermal incision to create flaps
Dermis
Sling
Superior flap secured to rib periosteum
Lateral flap secured to edge of pectoralis muscle
Medial flap secured to medial chest wall
Winn

LOSKEN 2010

# Dermal Suspension and Parenchymal Reshaping Mastopexy after Massive Weight Loss: Statistical Analysis with Concomitant Procedures from a Prospective Registry

J. Peter Rubin, M.D.
Jeffrey A. Gusenoff, M.D.
Devin Coon, B.A.
*Pittsburgh, Pa.*

**Background:** An increasing number of women are presenting for mastopexy after massive weight loss. The authors analyzed data from a prospective registry of massive weight loss patients who underwent the dermal suspension and parenchymal reshaping mastopexy alone or with concomitant operations to assess safety and efficacy.
**Methods:** One hundred eight female massive weight loss patients underwent mastopexy. Variables included operative time; time since gastric bypass; body mass index; revision; and complications such as seroma, dehiscence, hematoma, and infection. Univariate analyses were performed to assess outcome measures.
**Results:** Ninety-one patients underwent mastopexy without implant [mean age, 43.7 ± 9 years; mean intraoperative time, 8.5 ± 3 hours (mastopexy plus concomitant procedures), mean body mass index, 28.3 ± 3.9; mean time since gastric bypass, 27.5 ± 13.4 months; mean follow-up, 7.3 months], whereas 17 had augmentation/mastopexy. Eighty-five of 91 patients (93.4 percent) had multiple procedures performed. Wound dehiscence was the most common complication in 26 patients (29.2 percent); however, breast-specific complications overall occurred in only eight patients (8.8 percent). Body mass index and operative time did not predict an increase in complication rates. Patients who underwent augmentation/mastopexy had a lower current body mass index than those who had mastopexy alone ($p = 0.01$).
**Conclusions:** Dermal suspension, parenchymal reshaping mastopexy is a safe, effective, and durable method of treating the deflated breast after massive weight loss. Although patients with massive weight loss are likely to present for longer procedures and have a higher rate of wound-healing complications, these complications occur most frequently in areas other than the breast. (*Plast. Reconstr. Surg.* 123: 782, 2009.)

As bariatric procedures such as gastric bypass and laparoscopic banding increase in popularity for the surgical treatment of obesity and diabetes, a growing number of women are presenting for breast reshaping after massive weight loss.[1,2] The number of mastopexy operations has increased by 12 percent from 2005 to 2006 and by 96 percent since 2000.[3] Several procedures have been described to treat the deflated breast after massive weight loss.[4–10]

Breast deformities after massive weight loss vary significantly. Patients typically present with breast ptosis, medialization of the nipple-areola complex, and extension to a lateral chest roll. Procedures to correct the deflated breast often address the entire aesthetic unit, including the upper abdomen and lateral chest rolls. Augmen-

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**Disclosure:** *None of the authors has a financial interest to declare in relation to the content of this article.*

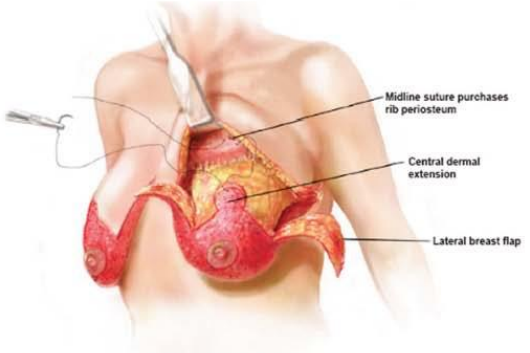


**Fig. 1.** Drawing demonstrating dermal suspension. After deepithelialization, skin flaps are raised 1 to 1.5 cm thick and undermined superiorly to the level of the clavicle. The central dermoglandular pedicle is secured to the second rib periosteum with permanent braided suture. The third rib can be used selectively. Lateral and medial flaps are raised and secured to rib periosteum at lower levels. (Reprinted with permission from Rubin JP. Mastopexy in the massive weight loss patient: Dermal suspension and total parenchymal reshaping. *Aesthetic Surg J.* 2006;26:214–222.)

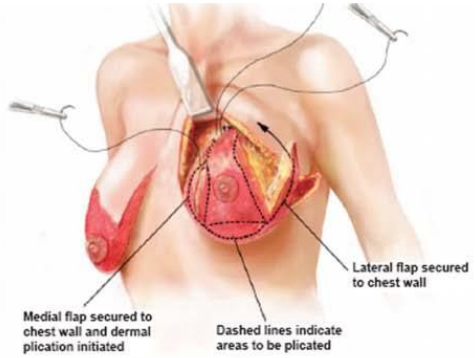


**Fig. 2.** Drawing demonstrating parenchymal reshaping. After securing the medial and lateral flaps to the chest wall, parenchymal reshaping is performed with interrupted and running absorbable suture to imbricate breast tissue and force projection centrally. (Reprinted with permission from Rubin JP. Mastopexy in the massive weight loss patient: Dermal suspension and total parenchymal reshaping. *Aesthetic Surg J.* 2006;26:214–222.)

# Mesh

- Goes: double skin technique then mesh
- DON’T TRY IT
- If you do think it has a place, go and learn it properly

# Medical complications

- Infection and dehiscence with fat necrosis
- Haematoma
- Sensory loss
- DVT
- Anaesthetic complications
- Nipple loss

# Aesthetic Complications

- Bottoming out
- Connecting scars and scars running off the breast
- Residual axillary fullness
- Empty upper poles
- Square breasts
- Poor implant cover with traction deformities