The “Fish” Mastopexy

Sir:

Traditional vertical mastopexy techniques do not explain how to lift a breast in a patient in whom the nipple is in the correct position and who has an aesthetically pleasing areola.1-3 Hidalgo introduced a Y-mastopexy technique for young patients with minimal nipple ptosis. Because of the grade I ptosis and a pleasing areolar diameter, a full circumareolar incision is unnecessary and instead a Y-extension to the vertical ellipse is made around the areola.4

For women desiring skin envelope tightening without nipple elevation, we suggest the fish mastopexy technique, in which a significant amount of skin horizontally is removed through a short vertical incision while nipple position is maintained. Three categories of women meet these criteria: the young Hidalgo patient, the patient who had a previous breast reduction and now seeks a mammaplasty for pseudoglandular ptosis, and the patient who underwent unilateral breast reconstruction who seeks a contralateral symmetrizing procedure for pseudoglandular ptosis. Unlike the traditional mastopexy patient, these patients have significant skin laxity coupled with a pleasing areola complex and a nipple that is not inferior to the inframammary fold.

Initial markings include the midline, inframammary fold, and breast meridian. The vertical skin incisions are drawn by displacing the breast from side to side. The edges of this ellipse will become the new breast meridian. Inferiorly, the vertical markings converge in the breast meridian 1 to 2 cm above the inframammary fold. They extend superiorly until 1 to 2 cm below the areolar margin, where a crescent is drawn. The inferior edge of the crescent is 1 to 2 cm below the areolar margin and the superior border is the areolar margin. The tips of the crescent are formed by connecting these two lines at the 9- and 3-o’clock positions of the areola. These markings create the outline of a fish (Fig. 1).

After deepithelialization, closure of the vertical limbs results in little or no distortion of the nipple-areola position. If a wide ellipse is removed, the dog-ears are cheated around the inferior areola border. Incisions are closed with 3-0 and 4-0 Polysorb (Covidien, Mansfield, Mass.)/Vicryl (Ethicon, Inc., Somerville, N.J.) sutures.

Over 4 years, the senior author (J.A.A.) performed the fish mastopexy in 15 of 59 mastopexy procedures (25 percent). Patients ranged in age from 34 to 71 years. Most patients sought symmetrizing procedures after breast reconstruction with an implant. No complications occurred. The technique reliably led to symmetrical breasts, with an unchanged nipple-areola complex location and minimal scar burden (Fig. 2).

The fish mastopexy should be considered when operating on a nipple-areola complex at or above the
inframammary fold with ptosis of the glandular breast below the inframammary fold. The crescent incision around the lower half of the areola allows for the dog-ears of the vertical excision to be cheated around the nipple-areola complex; thus, a wider ellipse can be removed with a shorter vertical incision. By not incising the superior aspect of the areola, the normal pigmented transition is maintained without scarring, leading to a reduced perception of the scar pattern.

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REFERENCES


Evaluation, Comparison, and Analysis of Postoperative Injury between Submuscular and Retroglandular Augmentation Mammoplasty

Sir:

Generally, the plane of prosthetic placement is easy to determine, but sometimes both planes seem reasonable. If the degree of surgical injury is different between submuscular and retroglandular augmentation mammoplasty, the one with less injury should be chosen. This research was designed to evaluate the difference in the degree of injury between them.

Two hundred sixty-eight patients who underwent augmentation mammoplasty in our department from June of 2003 to March of 2010 were analyzed, with ages between 17 and 49 years (average, 33.4 years). They were divided into the submuscular group (184 patients) and the retroglandular group (84 patients).

Surgical procedures were standardized, and suction drains were placed. Drains were removed when unilateral volume was less than 30 ml and the color of the output turned light. Unilateral drainage volume (in milliliters), drainage duration (in days), and use of an analgesic pump and other analgesics were noted. Data were analyzed with SPSS 13.0 (SPSS, Inc., Chicago, Ill.) using the independent samples t test or chi-square test.

Unilateral drainage volume and duration were 156.3 ± 121.1 ml and 5.06 ± 1.78 days in the submuscular group and 104.6 ± 15 ml and 5.06 ± 1.78 days in the retroglandular group. The volume of the submuscular group was significantly greater than that of the retroglandular group (p < 0.05), but there was no statistical difference in duration (p > 0.05). For patients who did not use analgesic pumps, the rate of postoperative analgesic use by those in the submuscular group was significantly lower than for those in the submuscular group (p < 0.05), whereas for those who used analgesic pumps, there was no statistical difference (p > 0.05) (Table 1).

Choice of prosthetic plane for augmentation mammoplasty depends on the original breast volume, degree of ptosis, objective factors, and the patient’s opinion, and sometimes is hard to determine. Following the minimally invasive principle, the operation with less injury should be chosen. There is little literature reporting the difference between them regarding injury at present. Exudates could reflect the degree of injury, drainage volume indirectly represents exudation, and postoperative pain is also another injury index. The purpose of this research was to evaluate

Table 1. Use of Postoperative Analgesics

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<thead>
<tr>
<th></th>
<th>Submuscular Group</th>
<th>Retroglandular Group</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Used</td>
<td>Not Used</td>
</tr>
<tr>
<td>With pump</td>
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<td>Without pump</td>
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<td>68</td>
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<tr>
<td>Total</td>
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