

The Importance of the Breast Aging Process in the Treatment of Breast Asymmetries

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There is a natural asymmetry in female breast. When the difference in the shape, size or position is visible and represents a psychological problem for the patient, surgical correction is mandatory and represents one of the greatest challenges for a plastic surgeon. In 1968 Hueston [1] evaluated the different causes of breast asymmetry and its psychosocial impact. Liu YJ and Thomson JG [2] in their work studied the ideal anthropomorphic values of the female; breast asymmetry and insufficient cleavage resulted as the most important issues affecting the esthetic outcome. Insufficient cleavage with lack of fullness in to the supero-medial quadrant of the breast had the most negative effect on aesthetic value. Several techniques have been proposed for the treatment of breast asymmetries. Often the surgeon must use different approaches on each breast in order to achieve the best balance and harmony. Thus, the surgeon must have good knowledge of the various operative techniques and plentiful clinical experience, as well as good aesthetic sense. Mammary asymmetry can be divided in congenital and acquired; the latter may be a consequence of surgery, trauma, burn injuries or radiation therapy. In this paper we focused on long term results in the treatment of congenital asymmetries. Mammary asymmetries can be classified as volume, positional, shape and NAC asymmetries and they are often present at the same time. Tuberous breasts constitute a further challenge. It is characterized by three main features: a constricting ring at the base of the breast that leads to herniation of breast tissue towards the nipple areola complex, hypoplastic breast tissue in the lower quadrants, abnormal elevation of the inframammary fold and asymmetry of the breasts [3]. In literature many different techniques have been described for treatment of the tuberous breast deformity. These include augmentation with or without tissue expansion, NAC reduction, parenchymal scoring, and

a variety of glanduloplasty techniques [4,5]. In 2007 Pacifico MD and Kang NV [6] suggested a high incidence of tuberous breast deformity in women presenting with breast asymmetry. From January 2007 to January 2013, 40 women underwent surgery for congenital breast asymmetry; they were all operated by the same surgeon. The key points of our decision making and preoperative planning were: preserve the glandular function, obtain the best shape with the less visible scar, evaluate volume differences between the two breasts, correct tuberous breast deformity when present, avoid complications and beware of long term results. The average age was 25, 3 ranging from 18 to 32. The treatment of mammary asymmetries entailed different surgical approaches. In all patients mammary silicone implants were used to achieve the final result. An attempt was made to minimize the difference in volume between the two implants which was at a maximum of 40 cc. All patients presented positional and volume asymmetry with different grade of ptosis according to Regnault's classification [7]. Volume differences were studied using the preoperative sizing method described by Hidalgo [8]; visual breast symmetry was obtained by positioning the appropriate size in the bra. The test was also used to have an indication of the volume of breast tissue to reduce from the hypertrophic breast when present [9]. In 12 patients minor breast ptosis was corrected only with breast implants. In 13 cases we corrected the moderate breast ptosis with Lejoure's technique [10] in order to match the contralateral one before to insert the implant. In 10 patients out of 40 we noticed a significant breast volume discrepancy. Hypertrophic breast was reduced to match the contralateral one and in all cases, following patient's desire, two prostheses as similar as possible were used to achieve the final correction and a long lasting result. 15 patients had different degrees of tuberous breast deformity. In these cases the deformity was corrected using Gasperoni or Muti techniques [11-12]. Our therapeutic choices were based on the need to ensure good shape, symmetry and position of the breast as well as a long lasting result with a similar aging process of the breast. To achieve these results it was always necessary to adjust the position, volume and shape of the hypertrophic and/or ptotic breast to the Hypoplastic one. This implied breast lifts and/or breast reduction reshaping the breast according to the contralateral one. At the end of the procedure, we implanted two prostheses that did not diverge significantly in volume. We believe that the key point to obtain an equal breast ageing process is to leave the most similar amount of breast tissue as possible in each



Figure 1: Mammary asymmetry, Right breast reduction with Lejoure's technique with 290 cc silicone sub-fascial prostheses placement, Left breast augmentation with 325 cc sub-fascial silicone prostheses placement.

Above left pre-operative frontal view, above Right Pre-operative side view. Down left 4 year control frontal view, downright 4 year control side view.

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Figure 2: Severe breast asymmetry with left breast ptosis, left breast mastopexy, Bilateral 380 cc sub-fascial silicone prostheses placement. Left pre-operative view, Right post-operative 2 year control

breast. The most important issue seems to be the proportion between the mammary gland and the prostheses. Our long term controls reveal an equal grade of ptosis and a similar ageing process of the two breasts; this is due to the presence, in each side, of the same ratio between the volume of breast tissue left and the volume of the implant placed (Figure 1 and 2).

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