My View

Breast Augmentation: Enhanced Visualization With the Endoscopic Transaxillary Technique

The transaxillary approach to augmentation mammoplasty seems to have gained new popularity with the advent of endoscopic techniques. Patients often request a transaxillary approach simply to avoid scars on the breast. As a surgeon, I find the transaxillary technique enjoyable because it is rapid, efficient, and—with the use of endoscopic techniques—reliable as well. In addition, the procedure creates a certain aesthetic pleasure of its own from the excellent visualization of regional anatomy. Personally, I find the visualization from a transaxillary endoscopic route superior to all other approaches, not only because of the wide angle and excellent clarity of the endoscopic view, but also because the endoscopic perspective is at a right angle to the pectoralis major origins, where the majority of dissection takes place. Traditional transaxillary augmentation is a blind procedure with less control of dissection and is hampered by the inability to accurately locate and address intraoperative bleeding. Although some surgeons are pleased with their results with a nonendoscopic transaxillary technique, I believe that implants tend to ride too high and control of dissection is too difficult.

Because the endoscope in essence converts the blind, traditional axillary dissection to an “open” procedure, the endoscopic transaxillary route allows equivalent pocket dissection to the other two routes. Hence, in many patients without significant ptosis, periareolar, inframammary, and endoscopic transaxillary approaches may all be considered. The choice may be based solely on the patient’s scar location preference. In patients with small areola or an absent or poorly defined inframammary fold, the transaxillary route may be particularly advantageous. Patients with ptosis, however, are generally treated with a periareolar incision to allow simultaneous mastopexy. When deemed appropriate and offered as an option, an endoscopic transaxillary augmentation is chosen by 50% to 60% of the patients in my practice, while the remainder are equally divided between inframammary and periareolar procedures.

Transaxillary augmentation can be completed under either a general anesthesia or intravenous sedation with local blocks. Once the axillary incision is made, dissection proceeds directly to the lateral pectoral border where a subpectoral pocket is made. The lateral-most pocket dissection is completed bluntly to avoid transecting the lateral intercostal nerve branches. An endoscopic retractor and endoscope are inserted, allowing clear view of the pectoralis major origins for division. Dividing the origin 5 to 10 mm above the attachments to the chest wall makes maneuvering of the cautery easier and allows for excellent control of bleeding, because divided perforators do not tend to retract below the level of external intercostal muscles. The prepectoral fascia can be readily identified from underneath after the muscle has been divided and can be preserved or divided, depending on pocket requirements. Generally the “learning curve” to feel comfortable with this endoscopic dissection encompasses only a few cases (probably 10 or less), although mastering the left side dissection for a right-handed surgeon (and vice versa) can be difficult. This is generally much easier for surgeons who “switch hands” during the dissection: the surgeon holds the endoscopic retractor in the left hand when dissecting the right breast, and switches to the right hand when dissecting on the left.

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-Felmont F. Eaves III, MD

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less than 1%. The areolar incision is ideal whether it is for hematoma, pocket-size adjustments, or size change. I generally make the areolar incision from the 5 o’clock to the 7 o’clock position, and I have received very positive feedback from patients pleased with the excellent incisions. The areola is a privileged area for wound healing, but an excellent closure technique is most important. I use 5-0 subcuticular Maxon® and a running 5-0 Prolene® pullout on the skin with Steri-strips®.

I have never been one to say that there is only one way to perform an operation. I do know that the technique described above is an absolutely reliable one that reduces capsular contracture. I have seen the fine results from the axillary technique, and I know that the incision can be excellent. On occasion, however, I have seen some prominent (or at least noticeable) axillary incisions that are not covered when a woman wears a swimsuit or sleeveless clothing. With the periareolar incision, there has been no significant incidence of permanent sensory loss, and I have never seen any skin loss from the small area of skin undermined.

Reference

Postoperative care for the transaxillary approach mirrors that for the other routes. I have not used drains, but these could be exteriorized through small secondary axillary incisions. With the excellent visualization of the endoscope, hematomas could be addressed through the existing incision, although I have yet to experience a hematoma in a patient undergoing endoscopic augmentation. Pain on arm motion during the first few postoperative days is a drawback to the axillary approach, and on occasion transient banding of the axillary scar is seen, although this has always resolved within a few weeks without specific treatment. Alterations in nipple sensibility seem to be infrequent and, if present, resolve within 1 to 2 months. Malposition of the implants has been infrequent, and over the past 5 years I have reoperated on only one patient to modify implant position, and in that instance a transaxillary route could be reused for capsulorrhaphy. Complete capsulectomy can also be performed through an axillary incision, but the dissection is generally quite tedious, and the surgeon may opt for another route. Implant replacement and lowering of the fold, however, should be quite simple from an endoscopic transaxillary approach.

As with the other methods of augmentation mammoplasty, the transaxillary route has a high level of patient satisfaction. Although many patients prefer an axillary scar and the scar quality there is usually very good, dissection of the implant pocket itself should theoretically be equivalent to that of the inframammary or periareolar approaches; therefore the operative results should be similar. The experiences of many surgeons seem to bear this out, and the addition of the endoscopic transaxillary technique to the armamentarium of the aesthetic surgeon should be a rewarding experience.

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