Breast Augmentation: Ease of Dissection With the Periareolar Technique

Since 1975 I have used only smooth, saline solution–filled implants inserted through an inferior areolar incision at the junction of the areola and breast skin for routine augmentation in more than 2000 patients. After I make the incision, I undermine the skin about 4 cm to the lower pole of the breast (or the upper pole with superior areolar incisions). When there is significant ptosis, I use either a superior areolar crescent resection (approximately 10%), a periareolar donut-type excision (approximately 5%), or full Wise mastopexy incisions (approximately 10%, depending on the degree of ptosis). Cutting cautery is used to dissect through the breast tissue to the pectoralis fascia. Pectoralis muscle fibers are bluntly separated (not cut) to enter the subpectoral space. Blunt dissection and cautery are used to develop the subpectoral pocket. The medial and inferior pectoralis muscle origins are partially released, but the overlying pectoralis fascia is left intact. When it is necessary to extend the pocket dissection beyond the most inferior origins of the pectoralis muscle fibers, I stay directly on the ribs to elevate some of the rectus muscle fibers.

After hemostasis, the pocket is irrigated with saline solution–bacitracin solution. Drains are inserted from inside out by use of a long trocar, bringing the drain out slightly lateral and inferior to the breast. Deep muscle sutures are inserted and the needles are cut off. The implant, prepared with clean gloves and covered with antibiotic foam, is inserted with the “no-touch technique” in which the implant is inserted through a sterile sleeve without touching the skin or breast tissue. The implant is filled with a closed filling system, and the fill tube is removed under direct vision. After the closure is completed, bacitracin/Marcaine® foam is injected up the drain tube. Finally, an Ace® bandage is wrapped around the chest over the superior hemisphere of the breasts to create some downward pressure against the implants.

I like this approach because it is direct, simple, and user-friendly, with no special equipment required other than a fiberoptic headlight and Army/Navy retractor. The central location of the incision gives the surgeon an excellent view of the entire pocket and allows easy finger dissection for final adjustments of the pocket after the implant is inserted and filled. Through the “fingertip test,” the surgeon can easily tell if tight or inelastic pectoralis muscle bands require further release.

This incision and exposure also allow the surgeon a direct view to easily perform intercostal nerve blocks before inserting the implant. The surgeon can directly observe implant fill tube removal and valve closure to avoid trapping tissue in the valve.

I believe that the importance of the no-touch sterile insertion technique in preventing a contaminated biofilm should not be underestimated. In my 1993 publication, the capsule rate was 0.6% for the last 1000 cases, whereas during 1992 to 1997, with the no-touch technique, the capsule rate was 0%.

Revisioanl surgery for any reason has been rare; most commonly it is because a patient wants larger implants. Although subpectoral implants often look high initially, with a proper muscle release they descend to the ideal level without further treatment in almost all cases. Approximately 1% of patients need secondary surgical adjustment of the implant pocket. The hematoma rate is...
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

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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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