Commentary on: Power-Assisted Liposuction Mammaplasty (PALM): A New Technique for Breast Reduction

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The authors should be congratulated for their new technique in breast reduction for large breasts and also for the efforts that they have put to make their technique reproducible by many surgeons. Breast reduction in high-risk patients has been associated with a significant increase of the postoperative complication rate. The major advantage of the described technique is reducing such risk to a minimum.

The power-assisted liposuction mammaplasty (PALM) technique is based on several concepts. The technique consists of a combination of liposuction of the breast with a skin excision and gland reshaping without undermining. Although breast liposuction is not a new concept in breast reduction surgery, the use of the liposuction has been difficult to perform in glandular and fibrous breasts. Additionally, liposuction might contribute to postoperative complications such as hematoma, seromas, and infection and therefore many plastic surgeons have abandoned liposuction in breast surgery. Others have limited liposuction to smooth dog-ears and/or to improve the breast contour and to define the inframammary fold.

However, the introduction of new technologies makes liposuction feasible even in glandular breast tissue. Power-assisted liposuction (PAL) is one of these methods, which facilitates suction by cavitation of the tissues. On the other hand, breast asymmetry might occur after breast liposuction. It is not precise to control the amount of the tissue removal by liposuction even if the aspirate volume is equal between the two breasts. Clinical experience in liposuction and in PAL technique is a must before starting such technique for breast reduction.

Maximizing blood supply to the gland and nipple-areola complex (NAC) has been the ultimate goal of modern techniques in breast reduction. Dual blood supply to the NAC has been adopted to enhance blood supply to the gland and to the NAC. Supero-medial, supero-lateral, septum-based pedicle, and many other techniques, have incorporated perforators from the internal mammary or intercostal vessels. In the PALM technique, the authors preserve the supero-latero and central pedicles which makes blood supply to the NAC more robust. Including Wuringer’s septum in every pedicle is possible and adds safety to the procedure.

The short scar concept was also applied to the PALM technique. Most of the presented cases of breast reduction were closed with a vertical scar. Only very large breasts with nipple elevation of more than 10 cm were closed with a short T-scar. The authors used an efficient algorithm to close the skin after breast reduction. In my personal algorithm, scar choice should be related to more than one factor such as nipple elevation (or nipple distance from the sternal notch); age and skin quality should also be considered.

Finally, the authors described an original method of gland fixation and closure by using barbed suture. Barbed sutures are a clear evolution in our field. They make closure faster and more efficient. Wounds with length discrepancy can be approximated more easily and the scar quality is better.

I’m still convinced there is no “best” technique that can be applied to all breast reductions; rather, there are masters of some techniques based on enormous experience that can apply a particular technique to most cases, and then there are other cases that require different, more tailored...
techniques. Therefore, modern plastic surgery should adopt a new strategy of technique selection depending on patient characteristics, rather than try to fit one technique to all patients/indications.

The PALM technique should be considered one of the modern techniques in breast reduction for a high-risk patient. The authors presented an excellent outcome in difficult patients who required breast reduction, and their complication rate was comparable to (if not better than) previously published series.

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