Response to “Can We Really Control the Inframammary Fold (IMF) in Breast Augmentation?”

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The author comments on two studies that describe suture techniques to control the inframammary fold (IMF). The author should be commended for his work but some answers and clarifications need to be added to his letter.

The author comments on the fact that the degree of lowering of the IMF was controlled and determined by the surgeons and wonders if we can really control the IMF in breast augmentation. This is actually exactly the case. When selecting the implant, we carefully analyze how the prosthesis relates to the existing boundaries of the breast as part of a biodimensional planning. In particular, it is important to analyze how the height of the implant meets the lower pole of the breast because an implant that exceeded by too much the natural boundaries of the breast can cause problems (such as double bubble deformity). For this reason, when selecting the implant, we need to carefully calculate where exactly the new IMF will be placed for a given implant and make sure that we do not lower it by too much. By this means, the position of the new IMF can be precisely calculated in the process of planning a breast augmentation and we can thus predict where it will be located after implantation. This is the basis of the “AK method” described by Hedén.

The author comments that it is uncertain whether large sutures are advantageous, stating that the strength of the bond depends on the scar tissue and not the suture. In our study we have described these advantages and it has also been reported in the literature that barbed sutures produce more fibrous scar tissue around the barbs compared to non-barbed suture materials. This may obviously be considered advantageous in achieving a stronger IMF fixation during the healing process. The author also comments on the fact that wounds are known to heal by a “one wound” concept, not respecting tissue layers. Our idea of a multilayer suture is to “restore” the anatomical planes by first fixing the new IMF to the thoracic fascia, then suturing together Scarpas fascia of the upper and lower wound and finally approximating the subcutaneous and cutaneous structures. Moreover, by using this multilayer suture technique, it is possible to achieve tension-free wound closure and therefore most likely a better looking scar. The tension on the skin edges of the wound is almost completely alleviated by the deep layers and it is an accepted principle that tension-free wounds result in better scars.

In the author’s opinion, to reduce bottoming out, the subpectoral pocket may be dissected slightly high on the chest, anticipating descent of the implant with time. In our opinion however, this would increase the risk for malposition. If the implant is on purpose placed higher on the chest, the result could be high riding implants, should the prosthesis not descend as much as expected. Also, there is some consensus recommendations for lowering the risk of malposition which suggest the importance of a snug “hand in glove” pocket dissection. Dissecting a bigger/higher pocket, as suggested by the author, is therefore something we do not consider appropriate.

The author states that in many women, the incision may be located about 1 cm cephalad to the IMF, rather than exactly in the IMF as recommended by Montemurro et al. We believe however that the word “incision” is not synonymous with “scar.” If the incision is placed 1 cm above the...
existing IMF, as the author suggests, this could result in a scar very visible in the middle of the breast lower pole after implantation. We do not recommend to place the incision in the IMF as the author commented but we instead recommend to calculate where the new IMF will be located and to place the incision there. By this means, the scar will be located exactly in the new IMF and will be inconspicuous.

The author states that measurements reveal that the IMF drops after breast augmentation and quotes one of his studies that shows how three months after surgery it has descended 0.71 cm on average (range, 0.06-1.55 cm) in patients treated with smooth, round, saline-filled implants inserted through an inframammary incision. However, by the author’s admission, the new IMF was not recreated nor sutured with extra support in these patients. Also, smooth saline-filled implants were used in his study, whereas textured silicone gel implants were used in our review. For these reasons, we do not think it is appropriate to compare the results of these two studies as they are based on, and include, completely different parameters.

Finally, the author states that our study claims a 100% follow-up at 6 months after surgery, commenting that this is quite extraordinary given the fact that cosmetic surgery patients are notoriously unreliable in keeping long-term follow-up appointments. In truth, we presented a retrospective study with a series of 436 patients who underwent primary breast augmentation performed by a single surgeon (P.M.) between January 2010 and June 2014, and we stated that all these patients had a minimum follow-up of 6 months. In other words, we never used the wording “consecutive patients” but we simply selected only those 436 patients who had a minimum follow-up of 6 months, out of all those patients who were operated in the same period of time. Data, including total number of consecutive patients operated in the above mentioned period of time and percentage of patients who actually were not included in the study due to too short follow-up, were eliminated by reviewers as considered not important.

Disclosures

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REFERENCES