Letter to the Editor

Comments on “Preliminary 3-Year Evaluation of Experience With SilkSurface and VelvetSurface Motiva Silicone Breast Implants: A Single-Center Experience With 5813 Consecutive Breast Augmentation Cases”

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Congratulations on your recently published article, “Preliminary 3-Year Evaluation of Experience With SilkSurface and VelvetSurface Motiva Silicone Breast Implants: A Single-Center Experience With 5813 Consecutive Breast Augmentation Cases.”1 By describing outcomes of the remarkable number of 5813 cases, the authors provide deep and valuable insights into their busy clinical practice. Sforza et al compare 2 types of Motiva implants with different surfaces (Velvet vs Silk Surface). The main question this industry-backed study tried to answer was about the safety of Motiva implants;1 however, some important technical questions remain that may be of broad interest to the readership.

A recently published independent article from our group also assesses safety and clinical outcomes of Motiva SilkSurface implants.2 We included 100 patients in our study; however, our population of exclusively primary breast augmentations utilizing an inframammary approach and submuscular implant positioning was very homogeneous. We had to modify our established augmentation technique significantly during transition to Motiva SilkSurface implants. To prevent implant dislocation, we strictly recommend in all cases a super tight pocket and advanced methods of inframammary fold fixation3 as well as intraoperative implant pocket assessment.4 Therefore, the technical description in our article is a detailed travel-book of wanderers who initially were lost but managed to get back on track, whereas Sforza et al provide a surgery-protocol that seems like a short notice on a postcard of successful navigators.

Due to the limited native-tissue interaction, one of the main characteristic of Motiva SilkSurface implants, we are hesitant to use them in patients requiring revision surgery or augmentation-mastopexy. According to our experience, this cohort is more prone to implant malpositioning due to the less firm soft tissue envelope. Although potential benefits of Motiva implants such as less capsule formation would also be advantageous for secondary or mastopexy patients, more mobility caused by the lack of integration with native tissue could be problematic. Therefore, we are highly interested in how Sforza et al have dealt with this patient cohort specifically.

Although the authors stated that there “were no exclusion criteria,” we are wondering if only Motiva implants have been used in your center within your study period. If not, it would

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be of great interest to know how patients have been selected to either receive Motiva or other implant types. Additionally, the authors mention broad expertise in implantation of macrotextured devices before starting with Motiva implants. This extensive data could easily be used to compare Motiva not only with Motiva implants but also with other macrotextured implants to gain additional evidence on these novel devices.

An overall complication rate of 0.76% is very impressive. Unfortunately, Sforza et al focus on extended descriptions of the implants and their material characteristics, while the exact surgical technique remains mysterious. Surgical success can be explained and summarized elegantly with the words from a famous Austrian, Arnold Schwarzenegger: “If you don’t find the time, if you don’t do the work, you don’t get the results.” Therefore, it would be a pity if the plastic surgery community cannot fully benefit from the pioneering work done by Sforza et al by not sharing their detailed surgical approach using Motiva implants in the context of various clinical scenarios.

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