Response to “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’”

Marcos Sforza, MD

Initially, I would like to extend my appreciation to Duscher et al for the letter supporting our work. However, I would like to address the comment that suggested this was an industry-backed study.

Our group would have immensely appreciated to have had support from the industry, especially when the cohort involves almost 6,000 consecutive patients. However, that was absolutely not the case, as was clearly declared in the disclosures. Moreover, we decided to focus our previous article on the novelty of the technology as Spear, Hammond and myself predicted years before this publication and believed that it would inspire a new and better generation of breast implants. Since then, we have all endeavored to establish a practical guideline on how to safely move from macrotextured/anatomical devices to the new bioengineered smooth, cell-friendly Motiva Implants.

Our cohort included not only straightforward cases of breast augmentation but also breast implant revisions and mastopexies. Dolan Park is also the main private provider of bariatric surgery in the United Kingdom that attracts many heavy weight-loss patients to the plastic surgery department. Poor skin quality and muscle laxity leading to large, challenging mastopexies with implants are common in our daily practice.

Once again, as clearly published in our article, there were no excluding criteria. All the patients who had Motiva implants were included in this study. In our hospital, surgeons had the option to offer a macrotextured round or anatomical device (Allergan, Santa Barbara, CA) as a more affordable option for patients compared with Motiva. However, approximately 1 year later, the surgeons opted for Motiva implants exclusively due to the low complication rates that would later be published in our article. The complication rates were almost 10 times less than any other devices in our practice. In regard to the Motiva range of implants, the choice is simple: patients who wanted anatomical devices or more natural results would be offered Motiva Ergonomix implants and those requiring more upper pole fullness would be advised to receive the Motiva round implants.

Nevertheless, we were privileged in that the team was comprised of experienced plastic surgeons with more than 3,000 cases individually logged in the last 10 years in our institution, and their experience spanned across macro-textured, micro-textured, and anatomical devices. Our team did not have to apply a learning curve because...
we had experienced unpredictability in the results with macrotextured implants in our young and active patient population. As a result, we had already made adjustments like the precise pocket dissection. It was clear to our experienced surgeons, from day 1, that if you design an anatomical pocket in a round smooth device, you will find yourself in troubled waters. It should be evident that every different breast implant surface demands adjustments in the surgical technique, which applies not only to Motiva implants. As plastic surgeons, we should not design a procedure in the same fashion for a polyurethane implant and an anatomical implant, for example. Nevertheless, your published paper is to be highly praised and will present a great value for surgeons migrating from macrotextured implants to these advanced devices and for those who are just starting in the realm of breast surgery.4

I would like to once again to point out that I could not agree with you more regarding the surgical technique described. We design a very, very tight pocket. The decision in relation to submuscular or subglandular pocket is based on the pinch as for any other implants. However, most of our surgeons do prefer the subglandular pocket for patients with poor skin quality when there is enough tissue. I personally believe that I have less pocket stretching in a subglandular position when the tissues have a lot of laxity because it makes it easier for the implants to dissect a “loose” muscle to the lateral part of the chest.

Regarding the positioning of scars on the inframammary fold (IMF), we use the ARC length provided by Motiva in their catalog. After deciding what implant we will use, we find the ARC length of the implant in the catalog in 2 forms: 40% and 45%. We use the 40% measurement when the implants will be in a submuscular pocket and the 45% measurement in case of a subglandular one (Figure 1). We measure half of the nipple-areola complex diameter, and the IMF scar is positioned under maximum stretch from the nipple with the addition of half of the nipple areola complex diameter plus the ARC length. If the surgeon is using an axillary or peri-areola incision, the same measurement is used to define the inferior limits of the pocket. All patients including the primary cases had IMF fixation, and I cannot overemphasize the importance of this last point in preventing complications as you described. I hope this clarifies what is simple to us and by no means mysterious.

We try to keep our practice simple, and the lower rate of complications that we experience with Motiva implants has helped us develop a very successful practice in the UK.

I would conclude this discussion by quoting your favorite Austrian, Arnold Schwarzenegger, when he said: “I welcome and seek your ideas, but do not bring me small ideas; bring me big ideas to match our future.” Let’s keep this great work that allows us the rare opportunity to reshape together the future of breast surgery with greater safety to our patients.

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REFERENCES


