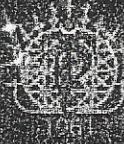


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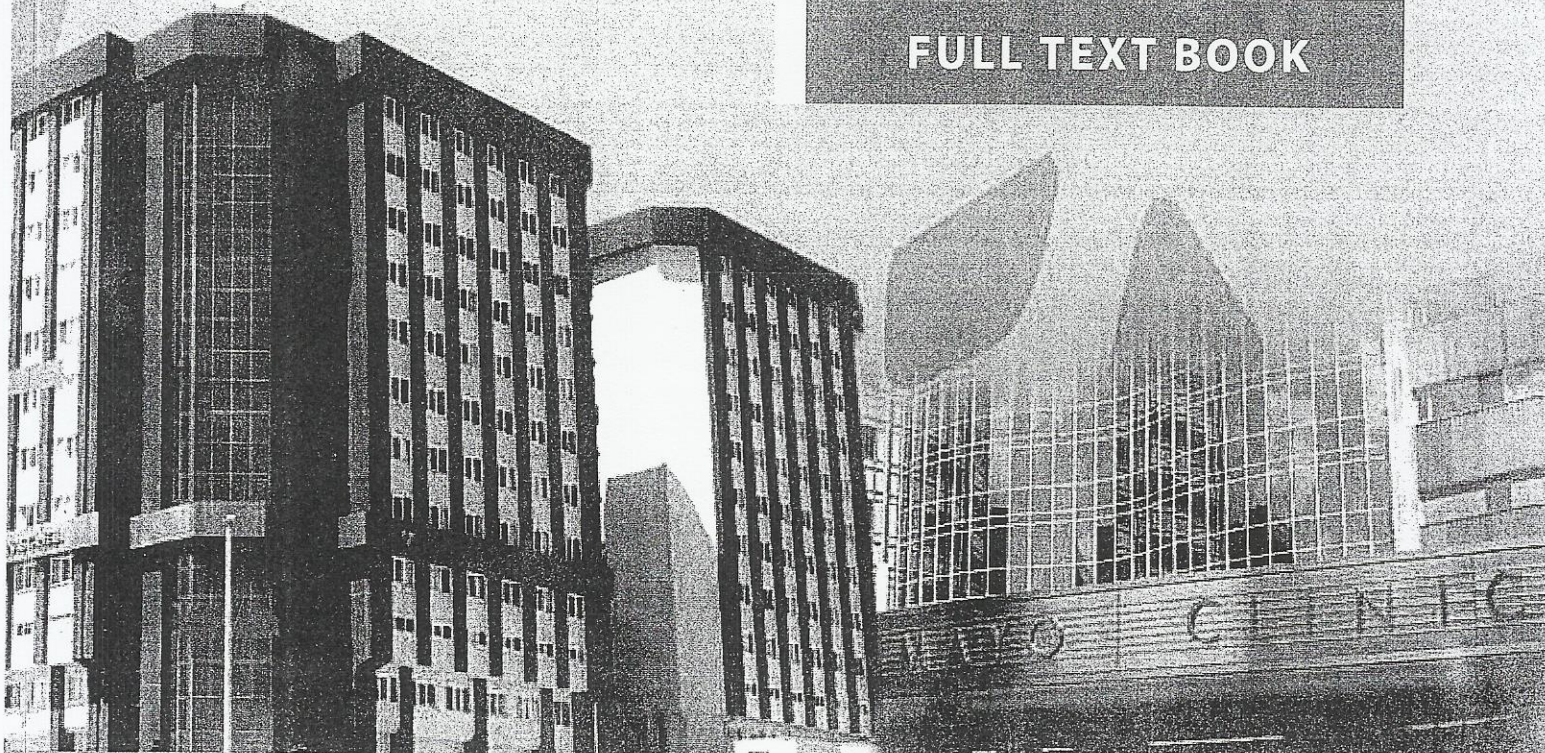
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**A - 061 VERTICAL MAMMAPLASTY MARKING USING THE KEY HOLE PATTERN**

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Introduction

Vertical mammoplasty offers less scar formation, better projection and appearance of the breasts, and lack of submammary scar formation. However, there still are difficulties in marking and resection with the vertical mammoplasty operation. The learning curve is believed to be long, and cosmetic outcomes may be inconsistent, although modifications to simplify the procedure have been proposed. In this presentation, we describe a new adaptation and a combination of two different marking methods for the technique.

Material-methods

The patient stands preoperatively in the upright position. Meridian and midline stripes of breast are marked from the middle point of the clavicle to the nipple-areola, and from the sternum to the umbilicus. The planned nipple location is determined to be at or just below the inframammary fold on the midaxial line. The distance between the suprasternal notch and the new nipple-areola is approximately 20 to 22 cm. After the submammary fold is marked, the lateral and medial excision points are determined using the inverted T technique. Lateral and medial vertical markings of skin resection are made while the breasts are pushed medially and then laterally, with the lines crossing directly upward from the upper abdomen to the lower breast sites. These two lines are joined in a curved fashion 2 to 4 cm above the submammary fold on the lower breast. We advocate using Lejour's procedure for marking the lower breast. While the upper breast being marked, the angle of the vertical limbs is determined as previously using the key hole pattern. With the breast skin tightly hold by the thumb and index finger of one hand, the angle points are marked approximately 7 cm below the new nipple site, which must be equidistant from the breast meridian. Then, the new nipple-areolas and angle points are joined by a curved line through the lower breast marking. The angle points also can be joined in the manner of a "key hole pattern" to the lateral and medial excision marks. A mosque-shaped new areolar line starts with one vertical limb, then crosses over the midline 2 cm above the new nipple point and ends on the opposite to vertical limb. The length of this shape is approximately 14 to 16 cm.

Results

A total of 29 patients with breast hypertrophy and ptosis were treated over a period of 4 years. One patient with asymmetric breasts underwent a unilateral reduction procedure using the same technique, and another patient who had ptosis bilaterally underwent mastopexy without resection of breast tissue. The amount of breast tissue removed ranged from 180 to 925 g per breast. Hematoma, skin necrosis, skin dehiscence, loss of nipple-areola sensitivity, and distortion were not observed. In one case, minimal glandular ptosis occurred after the mastopexy operation, and another case had delayed healing of the vertical suture in a reduction mammoplasty. Good breast appearance, projection, and symmetry were provided in the remainder of our cases. No complications related to sensibility or hypertrophic scarring were seen.

Discussion

In this study, we used the key hole pattern in vertical mammoplasty to obtain reliable results. Although our sample size was not large, the aesthetic results were satisfactory. We observed two complications: one related to minimal ptosis and another involving a delayed wound healing problem. This is an encouraging result, as compared with previous results [1-4]. We believe that the use of the key hole pattern in vertical mammoplasty provides a consistent estimation for the amount of dermoglandular tissue that should be removed at the inferior pole of the breast. This is very important for vertical mammoplasty because it is generally accepted that a most difficult aspect of the technique is the lack of a simple pattern applicable for all cases ranging from mastopexy to reduction weights exceeding 2 kg per breast. The use of the key hole pattern for marking in a standard Lejour vertical reduction mammoplasty helps the surgeon cope with the skin envelope and parenchymal reduction. Each modification of the vertical mammoplasty since Lassus's first description has made the procedure easier to understand and perform [2]. We previously used the key hole pattern for breast markings, but afterward used the mosque-shaped areolar line. Vertical scar breast reduction has been modified by Beer et al. [1] in 2001. In their study, they determined the angle between the two vertical lines on the new nipple site by holding the breasts gently and measuring vertical lines 9 cm long. Additionally, the new areola was inserted intraoperatively on the vertical suture line. We considered that holding the skin of the breast tightly would make the angle wider, creating a more conical breast shape. We also think that an angle pointing 7 cm below the new nipple site is reasonable. Lateral and medial resection areas have been

