NINA S. NAIDU
MD FACS

A Guide to Surgery of the Tuberous Breast

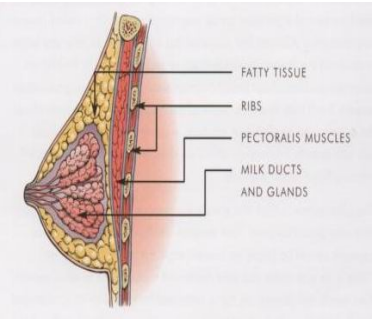
Inside this guide

Dear Patient,

Thank you for choosing to explore tuberous breast surgery with Dr. Naidu. This guide was written to help you understand your options for correction of the tuberous breast.

Please read the following information in its entirety prior to your visit, as this will make your time with us more productive. If you have any questions about anything contained in this material, please print out the relevant sections and we will be happy to discuss them with you at the time of your consultation. If anyone else will be involved in your decision-making, we ask that you bring him or her with you to your visit.

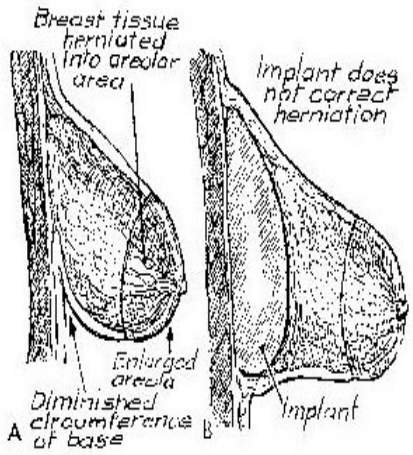
We look forward to meeting you.



Anatomy of the Breast

All breasts are made of fatty tissue, glands, ducts, and skin. Deep to the breast is the chest muscle (pectoralis major). During normal development of the breast, the tissue grows symmetrically across the chest, producing a round shape. Even in the setting of normal development, no woman has two breasts that match exactly. It is important that you understand the limitations that may exist due to characteristics of your own breast tissue.

Anatomy of the tuberous breast



During development of the tuberous breast, the growth of the tissue at the base of the breast is constricted. While the volume of breast tissue may be normal, it tends to be concentrated directly below the nipple. As a result, the breast may appear long and narrow, with herniation of the tissue through the nipple-areolar complex. The nipple-areolar complex tends to be enlarged, and the base of the breast may be relatively narrow. While the extent of deformity varies from one patient to the next, each of these elements must be addressed to adequately correct the tubular deformity. Patients with tuberous breasts almost always have significant asymmetry. If an implant is simply placed without releasing the breast tissue, the result will be a breast mound which falls over the implant.

(Image: *Rees TD, Aston SJ: The tuberous breast. Clin Plast Surg 1976; 3(2): 339-347.*)

Options for correction of the tuberous breast

Correction of the tuberous breast requires several elements:

1) reduction of the size of the nipple-areolar complex,

2) release of the constricted tissue at the base of the breast,

and

3) resolution of the herniation of tissue through the nipple-areolar complex.

In most cases, an implant is very helpful in providing not only volume but also shape to the reconstructed breast. The infra-mammary fold under the breast (where the underwire of a bra rests) may also need to be lowered. In severe cases, tissue expansion of the skin and existing breast tissue may be recommended prior to insertion of the final implant. Dr. Naidu will typically use an incision around the nipple-areolar complex only, with implant placement in one stage.

Breast implants: silicone versus saline

Effective November 17, 2006, both saline and silicone implants are FDA-approved for cosmetic use. Saline implants include both the traditional smooth round and newer Ideal® implant, while silicone gel implants consist of smooth round, textured round, and anatomic textured implants.

You will have the opportunity to hold and feel each type of implant during your consultation. Each type of implant has its unique benefits and trade-offs.

SILICONE

-contains a safe, cohesive silicone gel which feels more like natural breast tissue

-more expensive than saline implants

SALINE

-contains a salt-water solution which feels firmer than silicone

-higher risk of visible wrinkling and rippling

-lower price than silicone implants

Breast implants: location

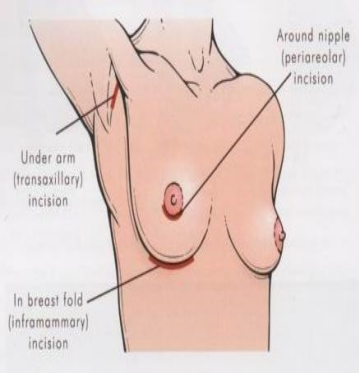
Breast implants can be placed either partially under the pectoralis muscle (submuscular) or over the muscle and under the breast tissue (subglandular). The goal is to provide optimal long-term coverage of your implants and to avoid creating deformities which cannot be corrected, including visible implant edges and rippling. For correction of the tuberous breast, Dr. Naidu recommends placement under the muscle. Clinical studies have repeatedly shown a decreased incidence of capsular contracture (tight scar tissue surrounding an implant) following implantation below the pectoralis muscle as opposed to above.

Breast implants: size

The best size implant for a given patient is determined by her specific measurements. These include the base width of your breast, the amount of stretch of your breast skin, and the amount of breast tissue you already have. The majority of tuberous patients opt for a modest implant which will correct their deformity. Very large implants are discouraged, as an implant which is too large for your tissues can result in excessive skin stretch, which may in turn necessitate further surgery. The edges of very large implants may also be visible under the skin. Because bra cup size are not standardized across manufacturers, a specific cup size cannot be guaranteed.

Breast implants: shape and texture

Both saline and silicone implants are made in round and teardrop shapes. Round implants may have either a smooth or textured surface. The benefit of texture is that the implant will not move as much within the breast pocket, which is especially important for teardrop implants. Dr. Naidu most frequently uses smooth round silicone gel implants for her tuberous breast patients.



Breast implants: incision locations

Although there are three commonly used incision locations for placement of breast implants (infra-mammary, peri-areolar, and trans-axillary), Dr. Naidu most frequently selects the peri-areolar incision for correction of the tuberous breast. This approach allows her to reduce the size of the nipple-areolar complex, reduce the herniated breast tissue, and release the constricted breast base through one incision. The infra-mammary fold can also be lowered through this incision. The breast implant is then placed below the muscle prior to closing the incision around the reduced areola.

Breast lifting +/- fat injection

Some tuberous breast patients do not require a significant release or implants. In such cases, they may be candidates for a breast lift, with or without fat injection. After the incisions are made, the breast tissue is lifted and reshaped, the nipple and areola are reduced and repositioned, and excess skin is removed.

Sutures are placed deep within the breast tissue to support the newly shaped breasts. The incisions are then closed with dissolvable sutures. The base of the breast is then examined, and if additional volume is needed, the patient's own fat can be injected at this time.

Secondary procedures

In some cases, a second procedure may be required to fill residual or recurrent contour defects on the inferior pole of the breast. Some patients wish to have the nipple-areolar complex reduced further, and this can be performed as a secondary procedure in the office under local anesthesia. A second procedure, if necessary, is typically performed at least 6 months following the initial surgery.

Risks of surgery

All surgery carries specific risks and benefits. These risks include but are not limited to the following:

1) Bleeding (<1%)
2) Infection (<1%)
3) implant rupture
4) scarring
5) capsular contracture of the implant (<5%)
6) pain
7) change in nipple or breast sensation
8) need for reoperation
9) inability to breastfeed (<5%)

Surgery and Anesthesia

Surgery is performed on an outpatient basis, either in the hospital or in an ambulatory surgery center. Surgery lasts 1 1/2 hours, and is performed under general anesthesia. Many patients worry about the risk of general anesthesia, but it is very safe and it assures that you will be completely comfortable during surgery. Prior to surgery you will be required to obtain routine bloodwork. The evening prior to surgery, you should not eat or drink anything after midnight. This ensures that you will have an empty stomach prior to surgery, which is very important for your anesthesiologist to care for you safely. You will need to have a responsible adult available to escort you home after surgery.

Recovery

Following surgery, you will awaken in the recovery area. Once you are fully alert, you will be given something to eat prior to discharge. You will need to be seen in the office 2-3 days following surgery.

You may return to most normal activities the day after surgery, but aerobic and sexual activity should be limited for 2 weeks. Most patients take 4-5 days off of work. You will be given detailed, written instructions regarding activity. Special bras, drains, and pumps are not used. You may notice some temporary swelling, tightness and numbness. If you notice sudden swelling of one or both breasts, severe pain, redness, drainage, or a fever, please contact the office immediately.

About Dr. Naidu

Nina S. Naidu, MD, FACS is Board Certified by the American Board of Plastic Surgery and is a Clinical Assistant Professor of Surgery at Weill Cornell Medical College. Her practice focuses on aesthetic and reconstructive surgery of the breast and body.

Dr. Naidu completed her undergraduate studies at The Johns Hopkins University and obtained her medical degree from Cornell University Medical College. After completing her general surgery and plastic surgery training at New York Presbyterian – Weill Cornell Medical Center, she performed an additional year of fellowship training at the University of Pennsylvania. She is an active member of the American Society of Plastic Surgeons (ASPS), the American Society for Aesthetic Plastic Surgeons (ASAPS), the International Society of Plastic Surgeons (ISAPS), and is a Fellow of the American College of Surgeons (ACS). Dr. Naidu maintains privileges at several New York hospitals including New York Presbyterian Hospital – Weill Cornell Medical Center; Manhattan Eye, Ear, & Throat Hospital; and Lenox Hill Hospital.

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